

# South African Social Housing Institutions and HIV/AIDS

**Social Housing Foundation Research Series  
December 2002**

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## Acknowledgements

The consultants drew on an extensive network of social housing and health practitioners in the research leading up to the preparation of this report. Thanks are due to all of the social housing institutions interviewed, especially to the persons who made special time available to participate in the discussions.

In late September, the consultants presented their work to an *imbizo* (workshop) organized by the Social Housing Foundation. Many thanks are due to the participants for their valuable contributions. The consultants appreciate that for many the subject matter was difficult to discuss, and are grateful for their candidness.

Various drafts of the questionnaire, and later the report, were also submitted to the reference group, formed by the Social Housing Foundation, for comment. The consultants wish to thank Odette Crofton, Georgina Jaffee, Samantha Naidu, Veni Naidu, and Dr Beryl Unterhalter for their useful contributions.

Finally, the consultants wish to acknowledge the support of their colleagues, namely Saranne Meyersfeld, an HIV/AIDS trainer and counsellor, and Robin Hamilton, a clinical psychologist who has worked in the field of HIV/AIDS. Both provided useful insights in the preparation of the final report. In addition, various members of the health profession assisted the consultants in understanding some of the more detailed issues surrounding the epidemic.

*This research was jointly funded by the Social Housing Foundation and Rooftops Canada/Abri International, with the financial support of the government of Canada provided through the Canadian International Development Agency (CIDA). The opinions contained in the report are those of the consultants and cannot be attributed to the Social Housing Foundation, Rooftops Canada, or CIDA.*

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# Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retrovirals
ATICC	AIDS Training and Information Counselling Centre
Cope	Cope Housing Association
CTCHC	Cape Town Community Housing Company
FMHC	First Metro Housing Company
GGICHC	Greater Germiston Inner City Housing Corporation
GMHA	Greater Middelburg Housing Association
HAEL	Housing Association East London
HBC	Home Based Care
HIV	Human Immuno-deficiency Virus
HLGC	Home Loan Guarantee Company
JHC	Johannesburg Housing Company
MTCT	Mother-to-child transmission
NHFC	National Housing Finance Corporation
Nkhensani	Nkhensani Housing Association
PHC	Primary Health Care
PIE	Prevention of Illegal Eviction from and Unlawful Occupation of Land Act 19 of 1998
PWA	People with AIDS
Semag	Semag Housing Association
SHA	Shayamoya Housing Association
SHF	Social Housing Foundation
SHI	Social Housing Institution
Simunye	Simunye Housing Association
Sohco	Abbreviation is accepted for: Social Housing Company
VCT	Voluntary Counselling and Testing
Vukuzakhe	Vukuzakhe Housing Association
YCH	Yeast City Housing

# Executive summary

The Social Housing Foundation, together with Rooftops Canada/Abri International, has identified the need to investigate current or planned responses to HIV/AIDS within the social housing sector. This is part of a broader intention on the part of both Rooftops and the Social Housing Foundation to mainstream HIV/AIDS programmes into all their work and partnership agreements, and to investigate the effects of the HIV/AIDS epidemic within the social housing sector.

## Objectives

The primary objective of the research was to understand and analyse the existing and planned educational, operational, and other responses to the HIV/AIDS epidemic among social housing institutions, and to make recommendations for improvements or new approaches. The hypothesis tested was that SHIs, by their nature, are able to play a special role in responding and finding solutions to both the prevention and effects of HIV/AIDS.

## Methodology

The research was exploratory, and the approach qualitative. Semi-structured interviews with 14 selected SHIs were supported by a literature study and key interviews with medical experts. Throughout, the consultants engaged with a reference group from the sector. The findings and recommendations were verified and modified at a workshop of stakeholders, including the interviewed SHIs.

## Apparently limited awareness in SHIs and among residents

The research found that, on the whole, while SHIs are aware that HIV/AIDS may be an issue among their residents and staff, very few had considered the effect this might have on their operations and on the lives of their residents. All but one SHI began the interview by saying they had nothing to say. With prompting, however, it became evident that while perhaps no formal discussions had taken place, there was talk in the corridors, and a number of informal assumptions were being made. Few SHIs have had direct and explicit experience with HIV/AIDS. A number suspect that one or more of their residents may have died of an AIDS-related disease; only two SHIs can confirm this, however, as a result of that person disclosing their status. Two SHIs note that their residents are particularly interested in the option of insurance, notwithstanding a more general resistance to rent increases. They suspect this is due to an awareness of HIV/AIDS among the resident population, and a consequent fear of eviction. A number of SHIs noted that their target market was within the high-risk group for HIV/AIDS. Those SHIs with high numbers of single female-headed households rightly expressed concern that the risk of prevalence among their resident population was high.

## Anticipated impact

Most SHIs suspect that HIV/AIDS will have the following impact on their operations:

**Financial:** It will threaten their financial viability as residents become ill and are unable to pay their rentals. Although all SHIs have long waiting lists (suggesting that filling vacancies will not be a problem), eviction procedures are expensive and involve a number of months in which rental is not paid on the unit.

**Social:** HIV/AIDS will impact upon intra-resident relations in a number of ways. The stigma associated with HIV/AIDS could result in discrimination, it could create a disjuncture between young and elderly residents, and could lead to general/community-wide depression as residents begin to get ill and die. It will also negatively impact upon resident-SHI relations, especially if residents feel the SHI is not dealing with the issue. This could lead to rental boycotts, which would further threaten the financial sustainability of the institution.

**Demand:** Some SHIs fear the impact of HIV/AIDS on the effective demand for their housing service. Very few boards have identified HIV/AIDS as a risk in decreasing the pool of potential residents. One SHI suggested that the stigma associated with HIV/AIDS might act as a disincentive for potential residents who are not affected to seek housing with the SHI.

Few SHIs have thought about the potential impact that HIV/AIDS will have on themselves, in terms of the institution's human resources capacity, the overall office 'mood', staff morale, productivity levels, and increased pressure on management.

## Responses

Only one SHI has developed an HIV/AIDS policy. This policy addresses awareness, education, and counselling, and deals with non-discrimination and confidentiality. It does not address the consequences of non-payment by a person who has developed full-blown AIDS and is unable to work.

Other SHIs have responded in an *ad hoc* manner. A number suggest that if they knew what to do, they could develop an appropriate response. **None of the SHIs have a plan for dealing with the likely eventuality that up to 25 per cent of their residents may become too ill to pay their rentals as a result of HIV/AIDS.**

The issues facing SHIs are complex. On the one hand, they operate as commercial enterprises, relying on rental income to cover operating and other expenses. Non-payment is treated very seriously and dealt with swiftly. SHIs are aware of the potential for one incident of non-payment to escalate into a full rent boycott – indeed a few of the SHIs interviewed are currently experiencing this. At this stage in their development, most SHIs are too young to accommodate the cash flow constraints of non-payment. Financial sustainability is, at present, justifiably their primary concern.

On the other hand, SHIs are by definition social institutions. But, in the context of many SHIs' precarious position in terms of income, as well as their relative youth, few SHIs have had the capacity to institute the social aspect of their businesses. By their own

admission, many SHIs operate as friendly landlords, compassionate in their response to a household's circumstances, but unable at this stage to undertake efforts that would foster community growth. When faced with the issue of HIV/AIDS, these constraints become particularly evident. At the very most, SHIs feel they are in a position to discuss the issue with their residents, holding workshops, and perhaps establishing some type of programme.

## Referral is the preferred response

When it comes to actually dealing with the circumstances of the resident who is HIV+, even those SHIs who are actively responding to HIV/AIDS advocate a referral approach, though they have not yet established the network to do this. Only two SHIs have considered how they might respond to a resident who developed full-blown AIDS, though their capacity in this regard is unclear. Still, for most SHIs, given the range of the other and in many ways more immediate problems that they face (non-payment, gang and drug-related violence, domestic violence, resident conflict, complaints, and so on), HIV/AIDS remains less visible.

## Can the HIV/AIDS sector accommodate referrals?

Given the intention of SHIs broadly to refer residents to other facilities, the consultants conducted a brief scan of the capacity of the HIV/AIDS sector to accommodate such referrals.

In terms of the policy environment, it was found that:

Housing policy has given little attention to HIV/AIDS, though there are current efforts to address this gap. HIV/AIDS policy has given little attention to housing.

Regarding the medical needs of a person with HIV/AIDS, there are provincial and local health authorities, and testing sites (which include pre- and post-test counselling). These are operating at full capacity however, but the nature of these sites indicates that there is potential for an SHI to develop personalised relationships with specific facilities, so that they can refer their residents directly, and know they will at least be admitted to the queue. Access to medication is limited and/or expensive.

The HIV/AIDS education, training, support, and counselling sector is vast, and there are many non-governmental organizations (NGOs) and other organizations that have sprung up to provide services. On the whole these facilities are stretched beyond their intended capacity, making access difficult. Critically, their emphasis is on providing self-help assistance rather than on providing direct care.

HIV/AIDS facilities that do provide care are seldom linked to shelter. There is virtually no additional capacity in the few existing care facilities.

**Social housing institutions are the last organization an affected household has contact with. SHIs' expectation that they can refer residents to HIV/AIDS facilities once they become ill, and to other accommodation once they are unable to meet their rental responsibilities, is simply not realistic.** To the extent that the facilities are able to

accommodate the person who is HIV+, virtually no support exists for their dependants. Following the inadequacies of a long line of potential support options, from government, which has provided very little support, through to NGOs, which are seriously overstretched, SHIs are the last institution with which the affected household has contact. In some cases, that household may be able to return to their 'home', possibly in a rural area, where there may be grandparents to look after the children. This cannot be an assumed norm, however. Thus, if the SHI does not support these households, they have to 'live rough', during which time the person with HIV/AIDS will get progressively more ill and die, leaving orphans on the street without support.

While a few initiatives do exist to develop an insurance product that would provide some security in times when ill-health or retrenchment means rental payment is threatened, they are not yet near completion. It is unlikely that the insurance will have the capacity to cover the household's expected non-payment all the way through until death. Thereafter, the challenges of accommodating orphans remains.

## **Social housing institutions must make a decision**

HIV/AIDS is a national socio-economic and health crisis. Institutions that have been established to address the needs arising from the crisis are struggling under the growing load. It is within this context that SHIs must decide on their role and responsibility. It is clearly going to be a difficult decision to make.

A few factors will influence the decision:

- legal responsibilities
- mandate of the SHI concerned
- contextual issues
- capacity considerations

SHIs must choose between doing nothing – and risk having both their financial and social sustainability threatened – and thinking proactively about how they might support their residents and staff. Many of the report's proposals do not require much in the way of additional financial resources or substantial organizational change. SHIs do have the potential, despite the constraints, to respond compassionately to the crisis.

## **The sector as a whole can also respond**

There are also responses that the social housing sector as a whole can make. The crisis can be an opportunity for the social housing sector to lead the way. The stakeholder workshop recommended that the Social Housing Foundation establishes a task team to work through the proposals emanating from this research, and develop a plan of action for the short-, medium-, and long term.

# Outline of the report

## **Part 1: About the research**

### ■ Section 1: Introduction

The background to and objectives of the research.

### ■ Section 2: Methodology

This section clarifies the terms of reference and methodology used for the study, and includes a comment on the research process and the validity of the results.

## **Part 2: Findings**

### ■ Section 3: Findings from the interviews

This section considers the responses of SHIs interviewed. It covers the current context of SHIs, levels of awareness and understanding regarding HIV/AIDS among SHIs, current responses to the epidemic and what SHIs think potential responses might be, the type of assistance SHIs seek from other organizations and their awareness of this capacity, and, finally, other issues raised in the course of the interviews.

### ■ Section 4: Findings from the literature study

This section considers the environment in which SHIs operate regarding HIV/AIDS. It first considers the progression of HIV/AIDS and the impact this has on both the resident or staff member, and their wider community. It then considers the enabling environment and relevant legislation. Finally, an analysis of the response to HIV/AIDS by the health and social services sector is provided.

## **Part 3: Proposals and the way forward**

### ■ Section 5: Proposals

This section begins to grapple with a way forward. It begins by introducing a decision-making framework that SHIs can use for defining the scope of their particular responsibility. It also includes proposals for appropriate and sustainable responses by SHIs to the various effects that HIV/AIDS might have on their residents or staff. A role for the Social Housing Foundation is also considered.

### ■ Section 6: The way forward

This section summarises the conclusions reached and proposes an immediate way forward.

## **Bibliography**

## **Annexures**

# Part one: About the research

## Section 1: Introduction

### Background

Rooftops Canada/Abri International (Rooftops), the international development programme of co-operative and social organizations in Canada, has embarked on a four-year programme to support social housing in South Africa. This programme, supported by the Canadian International Development Agency (CIDA), will help develop a sustainable social housing sector in South Africa that contributes to meeting national, provincial, and local housing goals by improving the housing, living, social, and economic conditions of workers and the urban poor. The programme is also committed to mainstreaming HIV/AIDS programmes in all its work and partnership agreements.

The Social Housing Foundation is a Section 21 company established in 1997 to facilitate, support, and promote the establishment of a sustainable social housing sector in South Africa. The organization initiates and supports capacity-building programmes for social housing institutions (SHIs) throughout South Africa, and assists with the development of an enabling policy framework for the sector. To this end it is collaborating with Rooftops to investigate the effects of the HIV/AIDS epidemic in the social housing sector.

The terms of reference for the research reported here, issued by the Social Housing Foundation and Rooftops, said:

HIV/AIDS is a major threat to the viability of social housing affecting the ability of the primary income earners to pay for rent and services. The loss of community and family leaders also affects the sustainability of social housing institutions. The HIV/AIDS crisis is both challenging social housing as well as providing social housing with new opportunities to adapt to the needs that are emerging as a result of this disease.

In the areas of HIV/AIDS prevention social housing institutions have a particular opportunity to reach out to different generations. This could have an important impact on attitudes and behaviour as well as the ability to mobilize HIV/AIDS education programmes at a grassroots level. These institutions could develop sufficient capacity to co-ordinate and monitor HIV/AIDS education in the housing association as well as in the wider community.

Social housing is especially well suited to develop new institutional models adapted especially to address the needs of orphans, single women/widow/ers or PWAs through combining the resources from a number of other programmes or organizations. The Department of Housing is developing a social housing framework that will provide an enabling environment and further development of social housing as a model for low-income housing delivery. This emergent framework recognises the need to explore the role which social housing can play in addressing housing needs emerging from this crisis.

A fully integrated approach to the development of social housing that both maintains the viability of the current institutions and identifies new housing models to meet new needs is desirable.

## Objectives

The primary objective of the research was to understand and analyse the existing and planned educational, operational, and other responses to the HIV/AIDS epidemic among SHIs, and to make recommendations for improvements or new approaches. The hypothesis tested was that SHIs, by their nature, are able to play a special role in responding to and finding solutions to both the prevention and effects of the HIV/AIDS epidemic.

Specific objectives were:

1. To determine the level of awareness and possible stigmatization of HIV/AIDS issues in SHIs and among their residents. This included, among other things, determining:
  - the number or perceived number of affected residents
  - the overall impact of HIV/AIDS on the SHIs currently
  - the anticipated future impact of HIV/AIDS on the SHIs and their residents
  - how the impact is being measured or assessed by the SHIs themselves.
2. To determine the presence of HIV/AIDS mitigation responses and education programmes, describing, among other aspects:
  - the nature of the mitigation responses and education programmes
  - the implementation and support given to the responses
  - the rationale for the specific type of responses
  - the barriers to implementation
  - the major drivers of the responses within the SHIs
  - the perceived impact of the responses
  - the persons/organizations responsible for their delivery
  - the role of other organizations – NGOs, local authorities, community-based organizations (CBOs), government departments – in supporting these responses.
3. To determine the extent to which the epidemic is being addressed in terms of its effect on policy and planning for new social housing opportunities within the specific SHIs.
4. To generate a combination of possible options and interventions for SHIs (including mitigation activities, educational opportunities, and policy options for dealing with all levels of the HIV/AIDS epidemic).

The research is intended to serve as a guideline for responses to HIV/AIDS in the social housing sector.

## Section 2: Methodology

The research was exploratory, involving qualitative, semi-structured interviews with selected SHIs, and supported by a focused review of relevant literature. Throughout the process, the consultants engaged with a reference group formed by the Social Housing Foundation, comprised of:

- Odette Crofton, Social Housing Foundation
- Georgina Jaffee, Rooftops
- Samantha Naidu, Department of Housing
- Veni Naidu, Perinatal HIV Research Unit
- Dr Beryl Unterhalter, Wits University

The findings were verified primarily by presenting them to a workshop to which all respondents were invited. In addition, ongoing testing of the findings and analysis with experts in the field refined the positions reached.

The consultants undertook the research in three phases:

- data collection
- analysis and verification
- conclusions

### Data collection

To address the research questions, data was gathered from three separate sources:

- interviews with representatives of SHIs
- the literature study
- key interviews with colleagues in the health care sector

### The interviews

#### Sampling

To support the need for experience-based responses, the consultants agreed with the Social Housing Foundation to interview only those SHIs that were currently managing existing stock. Of the 40 SHIs on the database with the Social Housing Foundation, 19 currently manage stock. Of these, 14 were interviewed (refer to annexure 1 for the list of respondents).

**Breakdown of sample of SHIs per province**

<b>Province</b>	<b>Total number of SHIs</b>	<b>SHIs currently managing stock</b>	<b>Final sample for the research</b>
Gauteng	16	10	8
Western Cape	7	1	1
Eastern Cape	7	3	2
KwaZulu-Natal	4	3	2
Northern Cape	0	0	0
Limpopo	0	0	0
Free State	1	1	0
Mpumalanga	3	1	1
North West	2	0	0
<b>Total</b>	<b>40</b>	<b>19</b>	<b>14</b>

The 14 SHIs were interviewed in 12 interviews. The three tenant buy-out initiatives (Nkhesani, Simunye and Vukuzakhe) were interviewed in a focus group session facilitated by Lesiba Seleke of the Gauteng Department of Housing.

The following SHIs were not interviewed:

- Randfontein Community Housing Company, Gauteng (could not be contacted)
- Seven Buildings Company, Johannesburg, Gauteng (could not be contacted)
- Ubunye Co-operative Housing, Pietermaritzburg, KwaZulu-Natal (could not be contacted)
- Abahlali Housing Association, Port Elizabeth, Eastern Cape (responded by e-mail and suggested discussion was premature)
- Reatlehile Housing Association, Welkom, Free State (consultants were unable to make contact within the time allowed, though Reatlehile had expressed interest in participating).

**The questionnaire**

The consultants developed their questionnaire in consultation with the Social Housing Foundation and the reference group. A draft questionnaire was tested in the first five interviews. On the basis of this experience, as well as arising from comments received from the Social Housing Foundation, the questionnaire was amended, and a refined questionnaire was used for the remaining seven interviews.

### The refined questionnaire

1. Can you please tell us about your SHI:
  - How does it work?
  - In what sort of environment do you operate?
  - What are the issues that you face on a daily basis?
2. Tell me about any discussions you have had in your SHI about HIV/AIDS:
  - What lead to these discussions?
  - What were the outcomes of the discussions?
3. Tell me about any talk around HIV/AIDS from the side of your residents/tenants.
4. Tell me about the potential effect of HIV/AIDS on tenants/residents:
  - Disclosure of status
  - Reasons for default/vacancies
  - Other (disability, discrimination, etc).
5. Tell me about the potential effect of HIV/AIDS on your SHI.
6. Let's discuss the types of responses that SHIs should or could consider to address HIV/AIDS:
  - Operational (policies, etc.)
  - Education
  - Other options (housing design, insurance mechanism, others)
7. What sort of assistance or support should HIV/AIDS-related and other organizations offer your SHI?

The first question sought to set the SHI in a particular context, so that the consultants would have a specific basis on which to understand subsequent responses.

With questions two and three, the consultants were seeking to understand the SHI's awareness of HIV/AIDS either in the broader environment or specifically within the SHI's immediate environment.

Questions four and five were to test how the SHI perceived that HIV/AIDS would affect its operations and the lives of its residents.

The sixth question sought to understand how the SHI was beginning to respond to HIV/AIDS. Where no such response was evident, the consultants considered how the SHI's existing operations would accommodate some sort of a response, should it become desirable.

Finally, in asking the seventh question, the consultants were interested in the broader network in which the SHI operates, and the extent to which this could be drawn upon in the future.

For all seven questions, the consultants prompted regularly for detail where it was not forthcoming.

### **The interview process**

Interviews were conducted face-to-face by the consultants. Kecia Rust was chosen to attend all interviews, given her experience in social housing and her role as leader of the research. This ensured the necessary continuity and progressive learning from one interview to the next. Xolani Kunene participated in all but two interviews, providing the necessary HIV/AIDS education experience. His participation also made it possible for the Shayamoya Housing Association interview to be conducted partly in Zulu. Sean Lotriet and Catherine Moat each participated in four interviews.

To maintain some degree of consistency the consultants asked to meet with the CEO or equivalent in each SHI. This was realized in all but three cases:

- Johannesburg Housing Company: The consultants met with the community development officer who is explicitly responsible for dealing with the company's HIV/AIDS policy.
- Greater Middelburg Housing Company: The consultants met with the property manager and the accountant. Neither the CEO nor the tenant liaison officer were available.
- Social Housing Company (SOCHO): The consultant met with the Chairperson of the Board.

Most of the interviews were conducted with just one person. In some others, an additional member of staff also participated. In certain other interviews, a broader representation was enjoyed:

- Shayamoya Housing Association: The interview comprised a member of the board, the Chief Administrator, a resident representative, and three community health care workers.
- Vukuzakhe, Nkensani, and Simunye: A focus group was held with representatives of these three SHIs, and included board members and resident representatives.
- Yeast City Housing: In addition to the acting CEO, the interview included a representative from YCH management, and a representative from their sister organization, Pretoria Community Ministries.

In addition, the consultants held telephonic interviews with the Built Environment Support Group (BESG) in Durban, and the Home Loan Guarantee Company (HLGC) in Johannesburg. These two organizations were interviewed on the basis of the work they had both done in the field. BESG has conducted research on the responses of HIV/AIDS housing and related service providers in the Durban metropolitan area. The HLGC is responsible for much of the training material used by some SHIs, and is currently investigating an insurance mechanism.

The consultants were aware that the research process was bound to evoke questions for the respondents that would not be answered in the interview, and so developed a contact list of organizations in the HIV/AIDS sector that might be available to offer support (attached as annexure 2).

### **Literature study**

The purpose of the literature study was to understand the broader environment in which SHIs and HIV/AIDS organizations operate, and the extent to which the two might intersect. The consultants explored the extent to which the housing sector considered issues of HIV/AIDS in both its policies and programmes, and the extent to which the HIV/AIDS sector considered housing and shelter issues.

### **Key interviews on specific issues**

Discussions were also held with various health practitioners working in the field of HIV/AIDS to confirm specific medical details associated with the disease and relevant to the study.

### **Validity and reliability of the data collected**

#### **The consultant**

The research was enhanced by the consultants' own experience in social housing and HIV/AIDS education:

Kecia Rust has had extensive experience in the social housing sector, having worked closely with the Social Housing Foundation in its early days in 1997, as well as with other organizations involved in social and co-operative housing.

Catherine Moat has detailed expertise in respect of the impact of HIV/AIDS on housing policy development in South Africa, and recently completed her Masters degree on the subject.

Xolani Kunene was trained as an HIV/AIDS educator in 1996, and has undertaken numerous research projects in the field, most recently for the Centre for Health Policy.

Sean Lotriet is an HIV/AIDS educator and corporate strategist in the development of organizational responses to HIV/AIDS. He currently helps manage and run the Johannesburg AIDS Training and Information Counselling Centre's (ATICC) HIV education and counselling programmes.

#### **The draft questionnaire**

Five of the interviews were conducted using a draft questionnaire, which was then refined for the final seven. This notwithstanding, the data from those first five interviews was rich and detailed. The consultants agreed among themselves that the data from those first five interviews is valid, as the subject matter is consistent across all twelve interviews. A standardized field notes format also assisted in this regard.

#### **Reliability**

The reliability of the data was constantly considered by the consulting team in discussion among themselves, based on their varied experiences in both social housing and HIV/AIDS. In this regard, the consultants agreed that SHIs are not much different from other private sector bodies in their response to HIV/AIDS.

## Analysis and verification

Within the framework of the research questions, the analysis followed a sequence:

Interviews were taped onto an audio cassette for later reference. Permission was requested, and in no case did the respondents decline.

One consultant drafted interview notes into a 'field notes' framework, and circulated this to the other team members for verification. Team members commented on the field notes, which were consequently amended. Key themes were identified. These themes became the basis for team discussions. Material collected from the various SHIs was reviewed, and relevant details were incorporated into the field notes. A rough matrix, setting out specific data and themes from each interview, was developed. This provided the opportunity for comparison.

The team met for three three-hour sessions to brainstorm the material and develop a response. A draft analysis of results was presented to the reference group and comments were received. These comments were worked into a draft presentation to the Social Housing Foundation, and still more comments were received. These comments were worked into a draft report, which was submitted to the reference group for comment.

## Conclusions

A final presentation, incorporating comments from both the reference group and the Social Housing Foundation, was made to an *imbizo* organized by the Social Housing Foundation and comprising key sector stakeholders (including respondents), and further comments were received. (The proceedings of the *imbizo* are captured in the 'HIV/AIDS *imbizo*: Note for the record, attached as annexure 3.). These comments, as well as comments received from the reference group on the written report, were worked into this final report.

**This report includes the outcomes and suggestions of all stakeholders as made in the various consultative processes that formed part of the research.**

# Part two: Findings

## Section 3:

### Findings from the interviews

This section includes a discussion on the current context in which SHIs find themselves, and reports on how the SHIs answered the seven questions in the questionnaire. In addition, it includes a brief discussion on how SHIs are appearing to define their individual scope of responsibility with respect to developing a response to HIV/AIDS.

#### **Current social housing context**

South Africa's social housing sector was officially recognized in policy terms in 1996 with the establishment of the institutional subsidy mechanism, and then again in 1997 with the establishment of the Social Housing Foundation. The support for social housing was based on two ideas. First, it was part of government's strategy to diversify tenure options, and second, SHIs were identified as catalysts in urban regeneration and integration processes. Housing practitioners and policy makers therefore interpret SHIs' role as extending beyond the provision of quality housing, to include various community development functions.

In principle, SHIs align themselves with the Social Housing Foundation's definition of social housing:

Social housing promotes improved quality of life and the integration of communities by providing affordable, high standard, subsidized housing with the added benefit of regenerating the area where the housing stock is located. The process is managed by viable, sustainable, independent institutions, which encourage the participation of residents in managing their own communities. Social housing is aimed at low-to-middle-income families and takes account of a wide variety of forms of tenure. It excludes immediate individual ownership.

Originally, social housing was conceptualized as a housing process that would protect low-income households from the hazards of immediate home ownership. The reality of their relative poverty made a quality product unaffordable, and also suggested that they lacked the capacity to make the necessary investments in maintenance and management that home ownership implies. Over time, as the idea was refined and the costs of building social housing became clear, social housing became implicitly targeted at households earning moderate incomes, within the subsidy limit of R3,500 per month but generally not less than R2,000 per month. This meant that households were generally employed, most often formally, though sometimes also informally.

## About the social housing institutions

Notwithstanding their similarities, the 14 SHIs interviewed are clearly different in many respects.

### Tier classification

The Social Housing Foundation has classified all SHIs in three different tiers.

**Tier 1 SHIs** are umbrella SHIs, and provide a property management function for a number of smaller institutions.

**Tier 2 SHIs** are independent SHIs who undertake all the development and management of the stock which they own, themselves. Part of their mission is to continuously develop new stock.

**Tier 3 SHIs** are resident-based institutions whose mission is simply to serve the needs of the existing residents within a defined number of units.

Most of the SHIs interviewed were tier 2 institutions.

### Social housing institutions interviewed, by tier classification

Tier 1	Tier 2	Tier 3
Cope Housing Association	Cape Town Community Housing Company First Metro Housing Company Greater Germiston Inner City Housing Corporation Housing Association East London Johannesburg Housing Company Greater Middelburg Housing Association Semag Housing Corporation Shayamoya Housing Association Social Housing Company Yeast City Housing	Nkensani Housing Association Simunye Housing Association Vukuzakhe Housing Association

### Champions

Beyond this, the SHIs are differentiated by their champions. Six of the institutions interviewed were established with significant local authority assistance. Many of these noted that their mandates were somehow linked to the broader goals of their local authorities.

Two of the SHIs were established by an NGO, and in each of these a sense of experimentation with what is possible in terms of the social aspect of social housing is evident.

The three tenant buy-out initiatives were established directly as a result of residents' collective efforts to access secure tenure in an inner city that had been abandoned by its landlords.

Three of the SHIs were established independently, without the assistance of an NGO or local authority, and without direct resident involvement – though all with substantial donor funding.

One of the SHIs is a housing co-operative.

An SHI's champion is important for a number of reasons.

First, it has an impact on its mandate and function, and its capacity to address non-housing matters such as HIV/AIDS.

Second, and perhaps more importantly, the type of champion appears to suggest the relative level of cohesion that exists within the resident community. In tenant buy-outs, for instance, the community exists even before the housing is secured. In the funded initiatives, residents are drawn as independent, nuclear entities. This point was noted by a number of such SHIs. A sense of community among the resident body is something that only develops over time. Levels of community cohesion provide an SHI with social capital, which will assist it in responding to HIV/AIDS.

Third, as a result of their origins, some institutions have 'sister', 'parent', or 'friendly' organizations that assist them in their operations. Shayamoya Housing Association, for instance, relies on the support of the Built Environment Support Group; the Greater Germiston Inner City Housing Corporation has staff who are seconded from the Germiston City Council; Yeast City Housing's acting general manager is seconded from the Pretoria Community Ministries. The Johannesburg Housing Company has received donor support from the European Union; and Cope Housing Association has received support from the Norwegian co-operative housing sector. This enhances the SHIs' capacity to undertake non-housing matters.

### **Age of the institutions**

Another factor worth considering is the relative youth of the SHIs. All of them are young, having been established within the last ten years, and, mostly, within the last four years. The Social Housing Company (SOHCO) has only been managing stock for about six months. The Greater Middelburg Housing Association has been managing stock for just under a year (the first residents occupied their units in October 2001). By comparison, Cope Housing Association, the Johannesburg Housing Company, and Yeast City Housing have been managing stock for at least five years (a long time in South Africa's social housing sector).

### Age of social housing institutions interviewed

Year institution began to manage stock	Social housing institution
1989	Cope Housing Association
1997	Johannesburg Housing Company Yeast City Housing
1998	Vukuzakhe Housing Association Simunye Housing Association Nkhesani Housing Association
1999	Housing Association East London First Metro Housing Company Cape Town Community Housing Company Greater Germiston Inner City Housing Corporation
2000	Semag Housing Association Shayamoya Housing Association
2001	Greater Middelburg Housing Association
2002	Social Housing Company (SOHCO)

Given their relative youth, most SHIs are only beginning to reach a level of operational sophistication that would allow them to think beyond their immediate property management responsibilities. Some of the SHIs are only drafting their policies now, having relied on oral policies to date. Very few SHIs have instituted non-housing services.

### Resident population and immediate context

One SHI noted that the nature of residents is predetermined by their context, history, and location. The market that is drawn to one SHI might be fundamentally different to the market drawn to another. Inner-city buildings may provide housing to employed workers who are only home in the evenings. SHIs located in townships may draw residents who are more politicized, more likely to institute a rent boycott. Best practice thus becomes very difficult to determine.

Most of the institutions agreed that younger, single women-headed households with young children make up a considerable proportion of their resident base. Young children and teenagers are common among all 14 institutions. It is worth noting that these two groups show the highest HIV/AIDS prevalence rates in South Africa.

In all of the institutions interviewed, affordability is an issue for residents, though in principle the resident population is not among the poorest of the poor.

A number of institutions indicated that they have bigger, more immediate problems than the prevalence of HIV/AIDS, including non-payment either as a result of poor budgeting or retrenchment, late payment as a result of residents trying to ride the system to their advantage, domestic violence and squabbles, gang- and drug-related violence, and so on. Four of the institutions indicated they are trying to overcome some form of rental boycott. These, plus one other, are focusing their efforts on improving the process of rental

payments. Another three are focusing on improving their governance and management systems, writing down oral policies, and developing and implementing new systems. Most institutions argued that their immediate focus is to develop enough housing to reach scale in terms of the relationship of income to operating expenses. Most agreed that, notwithstanding its importance, the issue of HIV/AIDS could be ignored because there are more immediately pressing crises.

### **Tenure**

The SHIs offer a range of tenure options: straightforward rental, co-operative tenure, and instalment sale. Tenure is significant in that it frames the role of the SHI with respect to the units. With rental units, the SHI owns the property, and, within the bounds of existing legislation, has the right to manage the property as it sees fit. With co-operatively owned units, the residents have collective rights in the management and operations of the SHI. With instalment sale units, residents develop ownership rights at some point during the repayment process.

The Social Housing Foundation notes that the impact that the tenure form has on the long-term sustainability of an SHI has not been adequately considered. In addition, issues of succession – should the legal owner die either before or after transfer – and the tenure security of a family if the breadwinner becomes ill as a result of HIV infection, are also relevant.

### **Awareness of HIV/AIDS**

Among the fourteen SHIs interviewed, there is clearly an awareness of HIV/AIDS as a significant issue warranting attention. While only three can claim to have had direct experience, eleven did suggest that they perceived HIV/AIDS to be an issue. Only one institution appeared to have no awareness whatsoever. Awareness notwithstanding, very few of the institutions have even begun to consider the likelihood of national level infection statistics being realized among their residents, not to mention their staff.

The issue of HIV/AIDS is most often understood in terms of its manifestation in the late stages – when a person is ill and unable to work, and therefore unable to pay the rent. Only a very few of the SHIs have considered the strong likelihood that a significant proportion of their currently ‘healthy’ residents or staff may be at an early stage of the disease, and require some form of response in the short to medium term. SHIs that have thought this far are unsure about what they should do.

## **Discussions within the institutions about HIV/AIDS**

Responses to the second question – ‘Tell me about any discussions you have had in your SHI about HIV/AIDS’ – were consistent across the SHIs: most had not addressed the issue directly.

### **The nature of the discussions**

All but three SHIs said that they have never discussed the issue directly, having referred to it only in passing, as part of another discussion.

Both of the SHIs that have addressed the issue directly have done so proactively, in terms of a broad awareness of the existence of HIV/AIDS in society and its potential impact on the SHI. One has used the discussion as a basis for developing a policy. The second has discussed the issue in terms of a potential area around which residents could participate.

The third SHI said the issue arose in response to its having to make arrangements for the dependants of a resident who had died.

### **Awareness at board level**

When prompted, five of the SHIs conceded that their board has considered the issue. Usually, however, this had been just in passing. A few SHIs said their board has identified HIV/AIDS as a potential risk to the SHI.

### **Focus on insurance**

One SHI said that the issue of insurance has been addressed in the National Association of Social Housing Organizations (NASHO). Six said that the relevance of HIV/AIDS has been raised in relation to insurance and various kinds of 'hardship' cover for residents.

### **Discussions about HIV/AIDS among staff**

Only one of the SHIs has held discussions internally about HIV/AIDS among staff. This was due to a member of staff disclosing first to the general manager and later to the staff. This person has become a resource for the SHI in helping it understand how to deal with its HIV+ residents.

Only one other SHI has discussed the issue in terms of its human resources policies. This discussion was facilitated by an external NGO.

#### **Tell me about any discussions you have had in your SHI about HIV/AIDS.**

- Discussions within the [SHI] arose in response to people dying with AIDS and directors were unable to access rentals. Also, the [SHI] was forced to consider what to do about remaining orphans.
- Within the [SHI] there has been some talk in terms of future projects. There has been very little formal discussion at board level – the board has limited awareness.
- HIV/AIDS has been identified in the business plan as one of the risks facing the [SHI], but the extent has not been quantified.

(from field notes)

## **Residents talking about HIV/AIDS**

Responses to Question 3 – 'Tell me about any talk around HIV/AIDS from the side of your residents' – were similar to those to Question 2.

### **The nature of discussions**

Generally, few institutions have noticed discussions among their residents.

One respondent remembered that the issue had been raised by elderly residents out of concern for the youth. He conceded that the issue has not received further attention, because the SHI lacks the capacity. The SHI is waiting for the residents to determine how the matter should be addressed.

In another SHI, awareness is evident although the stigma keeps talk quiet. One resident who happens to have been trained (not by the SHI) as a home-based caregiver is drawn on for support. This support is provided voluntarily, and there is no remuneration.

### **Focus on insurance**

Two SHIs noted that calls for insurance by their residents might be indicative of an awareness of HIV/AIDS and its prevalence among the resident population. In all cases, residents are clearly sensitive to rent increases, yet are still demanding that insurance products be implemented. Neither SHI was able to confirm if this is directly related to a fear of the impact of HIV/AIDS, or of the impact of unemployment.

A third SHI noted that any discussion among residents to which it would be party would have to be tied to the issue of insurance, because it is around tenure security that residents would think to raise HIV/AIDS with the SHI. This SHI raised the issue of HIV/AIDS in a residents' meeting, but the matter was not pursued for discussion.

### **Issues of trust**

Many SHIs noted that discussion among residents necessitated a level of trust both between residents themselves and between residents and the institution. They suggested that this has not yet been established, and consequently disclosure is unlikely.

One SHI said that even deaths are not reported because residents fear eviction.

Another SHI suggested that it is not getting information from the residents because it has not asked.

#### **Tell me about any talk around HIV/AIDS from the side of your residents/tenants.**

- Among residents, there has not been an explicit discussion. It is noted that the community does not want to address the issue because of the stigma involved.
- People will not admit an affordability problem, much less HIV/AIDS.
- People have not yet gotten to a stage where they can talk freely. The [SHI] respect this.
- The issue was first raised with residents when discussing the issue of non-payment. Out of this discussion arose the question of a safety net.

(from field notes)

## The effects of HIV/AIDS

### On the institution and on residents

Very few of the SHIs had considered the potential effect of HIV/AIDS on their operations, and not one had considered the effect on SHI staff. With the exception of one SHI, which had to place orphans (the cause of death of the parents was unknown), none was aware of having experienced any direct effects of HIV/AIDS.

Seven of the SHIs have no monitoring mechanism. The other seven use informal monitoring mechanisms to establish a sense of prevalence rates. In cases when a young resident dies as a result of an undisclosed illness, the SHI suspects this is HIV/AIDS-related. One SHI has been informally tracking the ages of its residents who have died. Of the 20 known deaths, it is estimated that 80 per cent were people in their twenties and thirties.

One SHI suggested that the effect of HIV/AIDS on both the residents and the SHI is critically tied to the institution's capacity to provide assistance. In this sense, with sufficient resources the effects could be mitigated. The availability of assistance would also promote disclosure.

On the whole, only one institution has begun to think strategically about HIV/AIDS and its implications for the institution. While most have some way of telling if a resident is HIV+, they had not considered the implications if 25 per cent of their resident population (or 40 per cent, as one SHI suggested) is terminally ill.

Still, SHIs are able to presume potential effects.

<b>Tell me about the potential effect of HIV/AIDS on tenants/residents and on your SHI</b>		
<b>Theme</b>	<b>Issue</b>	<b>Common responses</b>
<b>Financial sustainability</b>	Non-payment	<ul style="list-style-type: none"> <li>■ In terms of financial sustainability, the resident's ability to pay is critical.</li> <li>■ Don't know what we'd do if suddenly 20 per cent of residents became HIV+.</li> </ul>
	Dealing effectively with default	<ul style="list-style-type: none"> <li>■ With 7,000 families on the default savings waiting list, there is enough demand for [the SHI] to fill vacated units. In this context, the issue becomes one of dealing efficiently with default.</li> <li>■ Will have a big effect in terms of rental payments unless it can be dealt with within the first two months.</li> </ul>
	Negative demand	<ul style="list-style-type: none"> <li>■ Our board identified HIV/AIDS as a risk in terms of its impact on potential levels of demand in our target population.</li> <li>■ HIV/AIDS could undermine the reputation of [the SHI] as a place where such things happen, and therefore decrease demand.</li> </ul>
<b>Operational capacity</b>	Need to review policies	<ul style="list-style-type: none"> <li>■ HIV/AIDS will undermine the [SHI's] achievement of its vision and mission. It is critical that the [SHI] addresses this issue.</li> <li>■ If the [SHI] was able to achieve 90 per cent payment levels, it could swallow the costs of some households' non- or under-payment as a result of HIV/AIDS.</li> </ul>

Theme	Issue	Common responses
<b>Operational capacity</b>	Need to redesign units	<ul style="list-style-type: none"> <li>■ Physical access (this is a problem with two storey dwellings).</li> <li>■ Densities being achieved by the [SHI] could have an impact upon levels of infection.</li> </ul>
<b>Social sustainability</b>	Stigma	<ul style="list-style-type: none"> <li>■ Some residents might be offended if the issue was addressed.</li> <li>■ It is noted that the community doesn't want to address the issue because of the stigma involved. Sick people don't want to disclose their status, also because of their fear of stigma.</li> </ul>
	Orphans	<ul style="list-style-type: none"> <li>■ Socially, however, the impact of children being orphaned in the community is also significant and must be dealt with.</li> </ul>
	Social issues/ resident needs	<ul style="list-style-type: none"> <li>■ The person who is ill needs access to drugs, information, and immune boosters.</li> <li>■ There is no real sense of 'social' among residents of SHIs. This translates into there being little sense of how to seek support.</li> <li>■ Social housing is a tough market without the impact of HIV/AIDS.</li> <li>■ Having to replace people as a result of eviction or death would mean having to retrain them. Could undermine community cohesion.</li> </ul>

(from field notes)

Three broad themes emerged. Across all SHIs interviewed, issues of financial sustainability are of the greatest concern. These were variously expressed, ranging from an awareness of the risk of non-payment through to a worry that the epidemic will negatively impact upon the level of demand for social housing.

The impact on the institution's operational capacity was also expressed – especially to the extent that this necessitated a whole new approach towards thinking about property management.

Social sustainability issues were also raised as respondents began to consider the possibility that HIV/AIDS could seriously restructure their entire business model and development framework.

## Types of responses

### Overview

Few of the SHIs interviewed had undertaken any formal response to HIV/AIDS and none had developed comprehensive responses. Responses were either *ad hoc* and reactive (such as accommodating orphans), or in process (such as discussions around possible insurance mechanisms or the development of specific facilities).

On the whole, the consultants' interviews with the SHIs focused on the issues of raising awareness and non-payment. Treatment, care, and support were hardly discussed. Only a few SHIs suggested that they would engage in such activities; most said they would rather refer. Few SHIs have developed the necessary networks for referrals, however.

<b>Let's discuss the types of responses that SHIs should or could consider to address HIV/AIDS</b>		
<b>Theme</b>	<b>Issue</b>	<b>Common responses</b>
<b>Internal policy</b>	Specific policy	<ul style="list-style-type: none"> <li>■ The Johannesburg Housing Company (JHC) has developed an HIV/AIDS policy and charter. The HIV/AIDS policy function sits within the community development division of the JHC, which is responsible for the management of social issues in the SHI.</li> </ul>
<b>Awareness</b>	Workshop themes	<ul style="list-style-type: none"> <li>■ In June 2002, Housing Association East London (HAEL) hosted a Youth Week. One day of the week was dedicated to HIV/AIDS. Costa Gazi was invited as a keynote speaker, and the AIDS Training and Information Counselling Centre (ATICC) in East London also participated. The day's focus was well received. In March 2003, HAEI will launch its Health Focus Group to focus specifically on HIV/AIDS.</li> </ul>
	Education for residents/resident facilitators	<ul style="list-style-type: none"> <li>■ The JHC has developed a comprehensive education programme for residents, in which residents are trained as facilitators to run HIV/AIDS awareness programmes in JHC buildings. Funding for this programme has, however, dried up.</li> </ul>
	Train caretakers	<ul style="list-style-type: none"> <li>■ HAEI has also recently changed the qualifications for its 'housing supervisor' or caretaker role. The position is now staffed by an off-site social worker, who visits the project daily and deals with social and community development issues. Like JHC, HAEI has also employed a community development manager. This is the person who is responsible for addressing issues of HIV/AIDS.</li> </ul>
	AIDS Day activities	<ul style="list-style-type: none"> <li>■ Cope Housing Association's Housing Services Unit organized an event around National AIDS Day. Posters were put up and condoms were distributed. The need was identified from a prevention perspective, in terms of risk management, but there was no internal training that went alongside the event.</li> </ul>
	Referrals	<ul style="list-style-type: none"> <li>■ One SHI has referred a non-paying customer to an RDP house.</li> </ul>
<b>Support</b>	Special facilities	<ul style="list-style-type: none"> <li>■ Shayamoya Housing Association and Yeast City Housing (YCH) are both considering the development of facilities to accommodate persons affected by HIV/AIDS. In both cases, discussions with other service providers have been initiated about the ongoing management of these facilities once they are built. Neither has secured all of the funding necessary to proceed with their plans, though both are hopeful that fundraising will be successful.</li> </ul>
	Reconsidering housing design	<ul style="list-style-type: none"> <li>■ YCH is considering how to accommodate the needs of people with HIV/AIDS (PWAs) in housing they are now planning.</li> </ul>
	Welcome next of kin	<ul style="list-style-type: none"> <li>■ In one SHI, where a breadwinner died of an undisclosed illness, the next of kin were invited to stay in the unit and take responsibility for the orphans.</li> </ul>
<b>Risk management</b>	Developing insurance	<ul style="list-style-type: none"> <li>■ The Social Housing Company is currently reviewing insurance options, and considering how these might be equitably applied across its resident population.</li> </ul>
	Informal monitoring	<ul style="list-style-type: none"> <li>■ A number of SHIs noted that they have begun to monitor 'cause of death' as indicated on death certificates.</li> <li>■ One SHI instructed its caretakers to record the ages of persons who have died.</li> </ul>
<b>Other</b>	Follow local authority	<ul style="list-style-type: none"> <li>■ Two SHIs said they relied on the local authority to provide the lead with support in terms of social services.</li> </ul>

(from field notes)

While the above suggests considerable activity, it is worth noting that only one of the SHIs is responding in terms of a policy position on HIV/AIDS. The others are responding to specific problems particular to their resident body, as and when they arise.

Only two SHIs have developed a specific plan to encourage discussion and raise awareness. One other SHI has developed a programme around National AIDS Day.

Overall, SHIs appear to offer very little support to their residents. Those that do offer support often rely on the volunteer efforts of residents or members of the broader community. One of the SHIs relies heavily on the support of community health workers who do regular door-to-door visits. This same SHI also relies on one of its residents, who voluntarily provides home-based care support.

While risk management, and specifically issues of non-payment, were clearly important to the SHIs interviewed, and while many mentioned the need for some form of insurance or 'safety net', this remains a discussion rather than an actual intervention.

None of the SHIs have developed internal, human resources-related policies that deal with HIV/AIDS. One SHI explained that anonymous testing was a condition of work for the staff seconded from the local authority. This was imposed by the local authority and not by the SHI.

Indeed, the most proactive of SHIs appear to limit their conception of possible options to awareness raising and prevention strategies. None of them has considered HIV/AIDS becoming a visible reality among their current resident population. None can say they would know what to do if HIV-related illnesses meant that a large proportion of their residents were unable to honour their rental responsibilities.

### **Policy interventions**

The JHC is the only SHI with a specific HIV/AIDS policy

#### **Johannesburg Housing Company: AIDS Policy**

The policy was drafted in 1999 in response to the initiation of JHC's Community Development Programme and the appointment of a Community Development Manager. The Community Development Programme is a comprehensive approach to community development and involves tenant participation, entrepreneurial training, liaison services, a vulnerability programme and so on. The AIDS policy addresses issues of confidentiality, disclosure, counselling and education.

In terms of the AIDS policy, JHC has trained tenants as HIV/AIDS facilitators (ninety tenants were trained as part of the policy rollout). These facilitators are responsible for implementing HIV/AIDS programmes in their respective buildings. Since the adoption and first rollout of the policy, however, funding has become a problem. Funding initially secured for the purpose from USAID has been utilized, and new sources have not been identified. Another problem is the relative high turnover rate of tenants, which means that the training 'benefit' to JHC is lost when the tenants move on. Understanding that non-payment is often as a result of social factors, JHC has made the Community Development Manager responsible for following up cases of default with tenants. In this context, JHC is developing a programme for family financial management training which will include issues such as budgeting, insurance, developing a Will, and so on

(from Johannesburg Housing Company, 2002)

The JHC's HIV/AIDS policy addresses issues of confidentiality, disclosure, counselling, and education. In this, it is about prevention and limited support, but not about management once a household begins to feel the effects of the disease. JHC's strategy is to refer residents to appropriate services from other service providers in their neighbourhood. Beyond counselling, the policy does not address other support interventions (this is to be the brief of the HIV/AIDS facilitators in the various buildings), nor does it address housing design (this is captured informally in discussion between the community development manager and the property manager). The policy also does not address the human resources implications of HIV/AIDS.

### **Awareness intervention**

HAEL has been particularly proactive in addressing the need for awareness of HIV/AIDS among its residents. HAEL's first intervention involved dedicating the first day of its 'Youth Week' to the issue.

#### **HAEL Youth Week Programme (9 to 14 June 2002): Reportback from Day One**

The first day focused on HIV and AIDS and a presentation was done by Dr Costa Gazi. This was for the first time that young people of Belgravia valley were invited in this programme. Other organizations were also invited to participate. Youth responded very well and the level of participation was good. The programme was not only attended by the youth. Old people showed interest and they attended. The major aim of this programme was to educate and raise awareness on HIV and AIDS. The target group was the youth because they are the most vulnerable sector that is being affected by the disease. The structure of the presentation was very simple and that led to effective participation.

#### **Lessons learned:**

- Youth learned that AIDS is the killer disease and that they need to be very careful.
- That during sexual intercourse they should use a condom.
- That they should talk about sex and educate other people.
- That a person with HIV should not be discriminated against.

(from unpublished HAEL report)

Following on from this day, HAEL has established a Health Focus Group, one of eight committee structures that it uses to encourage resident participation. The focus of this group is on HIV/AIDS and other health issues.

## HAEL's report on its Health Focus Group

### **Health Focus Group**

Most poor people are highly affected by the opportunistic diseases in South Africa and in the entire continent. This has affected many families that are unable to access medicines that will help them. There are many factors that contribute to this and one of them is the lack of knowledge on preventative measures of the disease. The major killing disease that is currently facing the world is the HIV and AIDS and this mainly is killing young people. The focus group becomes most important in providing the direction and the awareness raising programme. This group has so far established relationship with participating organizations on HIV and a presentation was done by these groups. We are also in the process of engaging with other organizations on HIV like TAC and the Department of Health so that joint programmes could be designed. The focus group will not only focus on HIV and AIDS but on other health issues that affect people.

### **Challenges facing the group**

Intensive training programmes should be designed for all interested people that want to participate on HIV and AIDS programmes. This forum that will speak in one voice should be formed in the area and also the neighbourhood should be part of this initiative. Municipality special programmes unit should also play a major role in setting up HIV and AIDS desk. More presentations are needed so that people can fully understand the consequences of these killing diseases. The consultant that will design the HIV and AIDS manual will have to be hired.

### **Education – Education – Education**

What could be the spin-offs?

People will speak in one voice on any form of the killer disease that may threaten their living environment. Many people would have been educated about the importance of health and prevention measures.

(from unpublished HAEL tenant participation proposal)

Another example of an awareness-based intervention is the JHC's HIV/AIDS charter, which sets out the minimum responsibilities of JHC staff and residents in respect of HIV/AIDS. It is printed in poster format, and can be found in the foyers or common areas of all JHC developments.

## **Johannesburg Housing Company HIV & AIDS Charter**

### **Preamble**

In the light of:

- the existing high HIV infections rate amongst economically active South Africans,
- the need for appropriate and relevant information to improve HIV/AIDS awareness and knowledge,
- the need to establish support systems for physical and psychological support,

This charter identifies some of the basic rights which all JHC tenants should enjoy and the duties of all the stakeholders.

### **Accommodation**

- Lease of accommodation will not be discriminatory against HIV+ people and no tenant will be required to disclose their HIV status.
- No restriction will be placed on the free movement of tenants with HIV within JHC units.

### **Confidentiality**

- Tenants with HIV/AIDS have a right to confidentiality and privacy concerning their health and HIV status.
- A tenant who contracts HIV will not be obliged to inform JHC management or other tenants.
- Tenants will have the right to disclose their status.

### **Education**

- JHC will play a major role to facilitate the implementation and management of an AIDS Programme in all its buildings.
- JHC will have an ongoing AIDS Programme in their buildings in partnership with the tenants and subject matter experts.
- All JHC tenants are free and welcome to participate in the HIV/AIDS Prevention Programme.

### **Counselling**

- JHC will facilitate the training of counsellors.
- Counselling will be confidential.
- JHC will facilitate further referrals for counselling care and support.

**JHC acknowledges that HIV/AIDS is our common problem.  
It is time to act.**

Notwithstanding the commitment expressed by the JHC in respect of awareness and support, the institution relied on external funding to develop its policy and programme. This funding has now been used, and successful implementation of the charter relies on the JHC's finding additional funding.

## Other potential responses

SHIs were asked to consider what interventions they could make, given a situation in which their capacity and resources were not constrained. SHIs were able to brainstorm the range of potential responses based on their understanding of the types of interventions that would be needed. The following options were raised.

Theme	Issue	Common responses
<b>Financial sustainability</b>	Policy	<ul style="list-style-type: none"> <li>■ There is a huge need for an AIDS policy. The Social Housing Foundation should help in the development of this policy.</li> <li>■ The [SHI] would like to write a policy in co-operation with the residents.</li> <li>■ The Social Housing Foundation should develop HIV/AIDS relevant, generic policies that could be adapted by the [SHI].</li> </ul>
<b>Awareness</b>	Special workshops	<ul style="list-style-type: none"> <li>■ Consciousness raising: how to talk about HIV/AIDS</li> <li>■ Staff training – targeted, focused on compassion, tolerance, human rights, as well as operational requirements.</li> <li>■ 'How to make someone's life easier' – tips on how to support affected households easily and cost-effectively.</li> <li>■ A series of information workshops (basic health information, nutrition, communication, inclusivity of all people, behaviour change). Run by NGOs or clinics, free of charge.</li> </ul>
	Mainstream training materials	<ul style="list-style-type: none"> <li>■ Integrate AIDS awareness in existing programmes.</li> <li>■ Facilitate discussions with residents as part of broader process of engagement.</li> </ul>
	Training	<ul style="list-style-type: none"> <li>■ Youth campaign.</li> <li>■ Train residents to lead.</li> <li>■ Training of caregivers for children whose own caregivers are sick.</li> <li>■ Incentives for volunteers.</li> </ul>
	Referrals	<ul style="list-style-type: none"> <li>■ Refer to an RDP house.</li> <li>■ Refer to NGO and other service providers.</li> <li>■ Refer to clinics.</li> </ul>
<b>Support</b>	Informal, <i>ad hoc</i> responses	<ul style="list-style-type: none"> <li>■ Support for bereaved family.</li> <li>■ Food, clothing, child care support where needed -mobilize residents to provide.</li> </ul>
	Facilities	<ul style="list-style-type: none"> <li>■ 'Youth Empowerment Centre' in which the central message is HIV/AIDS prevention and support, and which focuses on training youth to act as home-based caregivers, educators and so on.</li> <li>■ Establish an orphanage.</li> <li>■ Develop a multi-purpose community centre that could be used as a site for anonymous testing treatment, care and support. This would give visiting doctors and other service providers the space to provide their service.</li> </ul>

Theme	Issue	Common responses
<b>Support</b>	Facilities	<ul style="list-style-type: none"> <li>■ Provide a hospice with free or affordable care.</li> <li>■ Access planning for the disabled.</li> <li>■ Condom dispensers.</li> </ul>
	Financial	<ul style="list-style-type: none"> <li>■ Subsidize rentals (forever/for a defined time).</li> <li>■ Embark a quota of subsidized rentals units for needy families.</li> <li>■ Access special dispensation from National Housing Finance Corporation.</li> </ul>
	Social	<ul style="list-style-type: none"> <li>■ Taking in orphans/building an orphanage.</li> <li>■ Arrangements for children who are orphaned. Allowing the unit to be transferred to the next of kin (irrespective of subsidy eligibility).</li> </ul>
<b>Risk management</b>	Insurance	<ul style="list-style-type: none"> <li>■ Insurance to cover rental once the breadwinner can no longer pay (either because of sickness or death).</li> <li>■ Income generation activities.</li> <li>■ Affordable access to immune system boosters (like 'e-pap' or 'hypo plus').</li> </ul>
	information	<ul style="list-style-type: none"> <li>■ Statistical modelling to suggest expected prevalence rates and to assist in long-term planning.</li> </ul>
	Dedicated staff	<ul style="list-style-type: none"> <li>■ Need dedicated staff to train internally – this person would be responsible for supplying information on a range of crisis issues.</li> </ul>
<b>Networks</b>	Build support with network SHIs/NGOs	<ul style="list-style-type: none"> <li>■ Link with JHC. Adapt their policy.</li> </ul>

(from field notes)

The above ideas, offered by SHIs, were often framed within a broader discussion that focused on the following issues:

- components of an HIV/AIDS policy
- concerns with financial sustainability
- the need to better understand the disease
- the need to identify the right role-players in framing the SHI's response.

### Components of an HIV/AIDS policy

A number of SHIs specifically identified the need for a policy that would deal with the range of scenarios that could arise as a result of HIV/AIDS. Some suggested the Social Housing Foundation should draft a generic policy and offer this to SHIs to adapt individually.

Some respondents were asked to explore what they thought would comprise a 'good' policy. Brainstorming, they suggested the following:

Attention to basic rights:

- non-discrimination of employment and confidentiality clause
- non-discrimination policy for residents (testing not an entry requirement), balanced with a policy for dealing with non-payment.

Attention to special needs:

- sick leave policy and a policy allowing time for medical treatment
- interim safety net to allow people to find alternative arrangements
- the establishment of a revolving fund to cover non-payment.

Attention to awareness and the consequent education and training needs:

- education to deal with peoples' fears and an approach for managing stigma
- training for resident committees, resident groups, and for real estate staff.

Attention to property development needs:

- unbundled design implications in terms of the family structure (i.e. no longer nuclear, sometimes child-headed, etc).

Only one SHI had accessed the JHC policy for consideration in their own context. Together, SHIs agreed that a policy framework or outline should be developed by the Social Housing Foundation. This recommendation was reinforced in the *imbizo*.

### **Concerns about financial sustainability**

SHIs' comments about the potential responses they could imagine were framed by quite apprehensive considerations of the costs, and the impact this would have on the long-term sustainability of the institution.

For some, this was expressed in terms of the added responsibility that the epidemic placed on their education and communication functions. Having to develop appropriate programmes, amend their existing materials, and so on, would require additional funding. In order for any effort into raising awareness of HIV/AIDS to have an impact, it would have to be sustainable – that is, it would have to be mainstreamed in the existing activities of the SHI.

Other SHIs expressed their financial sustainability concerns in terms of the risk of non-payment. Many SHIs were clearly frustrated with what they perceived to be an inability to help, given their dependence on regular income. These SHIs said they would like to be in a position to accommodate a family affected by HIV, and unable to pay their rental, through some sort of subsidized arrangement. One SHI wondered if the National Housing Finance Corporation (or other funders for that matter) would be prepared to write off a portion of the loan amount owing in cases where the SHI is responding to real social needs, such as supporting children who had been orphaned. This same SHI suggested that perhaps SHIs could factor subsidized rentals into their cost structures, so that a specific number of units could be made available to households affected by HIV/AIDS.

A few SHIs said that their anxiety regarding financial sustainability might be better managed if they had a real way of knowing the prevalence rates of HIV/AIDS among their resident population. One SHI suggested that statistical modelling could provide an indication of the sorts of prevalence rates SHIs could expect, and could assist in long-term planning.

### **The need to better understand the disease**

The third main theme relating to SHIs' perception of their capacity to respond related to their familiarity with the disease. An important recommendation, voiced by a number of respondents, was that all levels of SHI staff and management should be trained in how to talk about HIV/AIDS, how to respond when a person discloses, how to consider the issues involved.

One SHI acknowledged that under normal circumstances its natural focus would be on matters relating to property management – collection, vacancies, etc. Given this, focused training or education on the social aspects of HIV/AIDS was required to raise awareness among SHIs on issues such as the level of emotional stress that is experienced by a bereaved family when they are evicted. The SHI said that training was needed on how to act with respect in such situations.

Practical, day-to-day activities that could provide support for affected households while also allowing the SHI to carry out its affairs, were necessary. Critically, SHIs felt that this would support them in developing a trusting relationship with their residents.

Residents' level of openness is contingent on the nature of their relationship to the SHI. One SHI noted that:

... we should be, as SHIs, looking at wider community development issues, but tenant committees are focused on housing issues. If the building is going well, the tenant committee could be encouraged to expand its role. But there is too little capacity to pursue this.

The same SHI noted that residents do not tend to look to the SHI for social, non-housing-type services.

A few other SHIs noted that increased awareness will help people cope both socially and psychologically with their situation. This will also help residents support one another in dealing with the affects of HIV/AIDS.

### **Identifying the right role-players**

Most SHIs interviewed pondered the role they should play in addressing the impact of the disease on their resident population, given the diversity of role-players in the broader environment. In most cases, this diversity was supposed rather than confirmed, as SHIs had not identified who comprised the network of support providers in their area.

Some SHIs suggested that they were not the right organization to undertake a formal intervention in respect of HIV/AIDS.

One SHI noted that because they had been established by a local authority, they were subject to high degrees of politicization. This could mean that the HIV/AIDS response also ran the risk of being politicized.

All SHIs confirmed that the public sector should provide the additional support required by households affected by HIV/AIDS.

Among those SHIs who had resolved that they themselves did have a role to play, the potential role of the youth was highlighted. One SHI remembered when a local development NGO organized a youth trip to the coast. The focus of the trip was HIV/AIDS awareness, and youth were trained as counsellors and volunteer home-based care providers.

### **Succession policy**

While this information was not specifically requested, a number of SHIs raised constraints relating to policy on succession.

Two SHIs noted that there was no policy precedent for dealing with succession. Once a lessee passes away, the lease ceases to be valid. In principle, this means that the remaining occupants must be vacated, joining the waiting list behind others. Some SHIs acknowledged that they tried to stretch the policy to allow it to accommodate the remaining residents, especially if these were children and if there were elders that could move into the unit and resume payment responsibilities.

In SHIs that offer instalment sale, succession also becomes an issue should the breadwinner die before the sale has been completed. One SHI recommended that the Social Housing Foundation undertake to investigate the Alienation of Land Act in this regard.

## **Assistance from other organizations**

### **Overview**

Very few SHIs indicated that they had a network on which they could draw to assist households affected by HIV/AIDS.

Even the JHC, whose policy explicitly requires such a network, acknowledged that relationships with external service providers were still *ad hoc* and informal. Yeast City Housing (YCH) benefits from its 'sister' relationship with the Pretoria Community Ministries (PCM), especially to the extent that PCM provides HIV/AIDS education to residents in its own shelters who then often move into YCH stock. Still, YCH had not yet developed a relationship whereby PCM would provide specific education services to residents.

While a number of SHIs noted the importance of networks, only one had tried to formalize these into what it called a 'diversity team'. Its efforts were less than successful, it seems because the other organizations faced their own capacity constraints. HAEL had developed networks with the operators of local facilities (schools, synagogues, etc.), so that they could use these facilities for workshops and other functions.

Very few SHIs noted that residents affected by HIV/AIDS had nowhere else to go once they were evicted. If the SHI does not provide them with the various services they need, they are unlikely to get them elsewhere.

One SHI claimed that they would not make referrals because they did not want to accept responsibility for the service delivered by the referred organization.

#### **What sort of assistance or support should HIV/AIDS-related and other organizations offer your SHI?**

- There are no HIV/AIDS education organizations in our area.
- Anti-retrovirals are available and wanted, but they're too expensive for the target market.
- Limited to the public sector. The [SHI] hasn't yet engaged with the NGO sector.

(from field notes)

None of the SHIs took into consideration the housing sector institutions that have been established to assist them. Neither the Social Housing Foundation, nor the National Housing Finance Corporation (NHFC), nor Nurcha were identified as institutions that might offer assistance. That said, potential roles for specifically the Social Housing Foundation and the NHFC were highlighted in response to other questions.

## **Other issues**

In the course of discussion, a number of SHIs volunteered information that was not specifically asked for. Two sets of issues are worth recording: perceived constraints against implementing any sort of response, and the SHIs' sense of responsibility in forming a response.

### **Perceived constraints**

The most common constraint expressed was that there is no precedent. SHIs simply are at a loss about what to do. Coupled with this, internal capacity constraints in terms of both human resources and funds limited the desired response. Most SHIs noted that the lack of a social safety net had the effect of making the social and economic impacts of HIV/AIDS on the population at large, their problem. A few expressed a desire to know the prevalence rate among their residents and staff, and others also noted the dearth of support agencies to whom SHIs could potentially refer their residents and staff.

Together, SHIs identified four main gaps:

- The need for a policy on HIV/AIDS which especially considers issues related toorphans, non-payment, eviction, and human resources.
- A framework for discussing issues of HIV/AIDS with their residents and staff: Most confirmed that they did not know where to begin.

- The need for established networks with HIV/AIDS organizations: Most confirmed they were unaware of the services that existed.
- The lack of a social safety net brought the national crisis squarely at the door of the SHI.

### **Scope of responsibility**

Almost every interview led towards a discussion on the SHI's sense of their responsibility towards residents or staff who were somehow affected by HIV/AIDS. Few SHIs had given any attention to this question in the past, but were aware that an answer was central to their developing any response.

None of the SHIs spoke of their institution's responsibilities to a staff member, focusing rather on their relationship with their residents. Most SHIs said that they believed that their legal responsibility to residents ends with the provision of housing, and that anything further is 'extra'. One SHI noted that aside from being residents, residents were also employees, students, community members, and so on. In this regard, residents should also be getting support from the other organizations with which they develop contacts. It was thought that SHIs should not be the only organization responsible.

The desire to offer a humane and tolerant approach was expressed by almost all SHIs, though most noted that the issue of financial sustainability limited their capacity considerably.

One SHI emphasized that social housing involved people sharing their living spaces and living in close proximity to one another. The SHI said that this creates some sort of a responsibility on the part of the institution for education and awareness raising, specifically in terms of how HIV/AIDS impacts in such situations. It also suggests the need for certain levels of tolerance and caring that are specific to the role and function of the institution itself.

All but two SHIs said that non-payment for whatever reason would eventually lead to eviction. It was therefore a particular problem that there were no alternative forms of accommodation, save for the few RDP houses into which some residents could be 'right-sized' in an *ad hoc* manner. One SHI said that ultimately the scope of responsibility is defined by the market and its needs. Another SHI noted that there was no space in the current eviction policy to allow for dealing with the reasons for non-payment.

# Section 4: Findings from the literature study

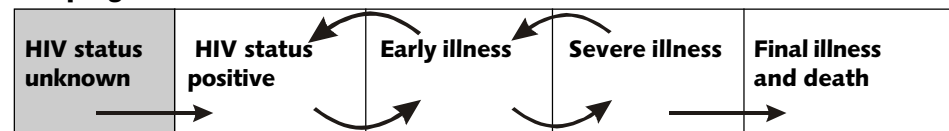
This section sets out the findings of the desktop study. It first considers the various impacts that HIV/AIDS has on infected and affected persons, and on the SHI. The various structures that exist to support the SHI in the social housing sector are then considered. Thereafter, the health and social services sector is considered to the extent that it might offer resources to SHIs.

## The impact on people and on the institution

### The progression of HIV/AIDS

It is useful to consider the impact that HIV/AIDS has over the course of the disease, from when a person’s status is unknown, through to when they develop full-blown AIDS, and eventually die.

### The progression of HIV/AIDS



It is important to note that this progression is not linear. Once a person is tested and found to be HIV+, they may continue in good health for some time. They may develop a minor illness as a result of their diminished immunity, get well again, and continue to function like someone who is HIV-. Over time, however, their immune system will weaken, and a minor illness may develop into a severe illness. If this illness is dealt with appropriately, however, they may become well again. Various immuno-boosters can help improve an HIV+ person’s immune system and their ability to become and remain healthy. Over time, a person’s health will fluctuate from health to illness and back again. In South Africa, the scenario is that after about 10 years, at most, the person’s immune system will be unable to cope, and without anti-retroviral treatment they will die.

Tracking the progression reveals that it is possible for a person to live positively with HIV. It is, however, important to keep in mind that resident populations in SHIs are generally poor young females with dependants. This is a high-risk category for HIV infection in South Africa.

### HIV prevalence among South African women aged 20-29 year

Age group	Prevalence rates from 1996–2000
20-24 years	Just under 30 percent
25-29 years	Just over 30 percent

## **The impact on the social housing institution and community**

### **HIV status: positive**

Once a person is diagnosed as HIV+ they become certain of their infected status, which they may, until such a point, only have suspected. Stress levels are set to rise as people take in the information that they are terminally ill. Stress is also caused by having to relay this information to family members, friends, colleagues, and communities. What HIV+ people do after they find out will either support their immune system and ward off infections, or lead to a deterioration of their condition. Correct nutrition, availability of medication, and access to health care for opportunistic illnesses all contribute to maintaining the individual's relative health. Being in a supportive emotional and physical environment will retard the progression of the virus.

### **Early illness**

At the stages of early illness and severe illness, an HIV+ person's fatigue increases and low-level infections may occur. They will regain their health and then fall ill again in a continuing and increasingly debilitating cycle. As a result, productivity is diminished, which then increases job insecurity and may result in decreased earnings or unemployment.

These factors undermine residents' ability to pay rent on time or at all. Possible job loss and decreased earnings means that funds needed for medical care may be diverted from rental. This in turn increases chances of evictions, and residents are less inclined to participate in community activities, which further undermines community cohesion.

The infected person's family and dependants are also affected by the virus. Their stress levels will rise as they come to terms with the ultimate loss of a loved one. Added to this may be concerns about the loss of income that person represents for their household. As the infected person becomes increasingly incapacitated, income earners in the family may be forced to stay at home to care for them, resulting in a further loss of income.

### **Severe illness**

Increasing medication and nutrition needs divert the household's income away from other essentials: schooling, clothing, and housing. Coping and survival mechanisms are under severe stress. Stigma and alienation that are commonplace in relation to the disease exacerbate these already dire conditions.

Decreasing health may also impact on the care and supervision given to children. Neglect may result in their staying away from school and being exposed to delinquent behaviour. It also decreases children's chances of obtaining a satisfactory education, thus diminishing their options for getting out of the cycle of poverty.

### **Final illness and death**

In the final illness and death stage of the disease, diminished means and a general inability to pay results in an increasing chance of eviction and homelessness. Poverty and orphans become real. Children are traumatized and vulnerable. Communities may try to care for them, but poor communities have little, and so feeding and clothing another person is often not an option. The emotional impact of having families or children forced out of their homes

may have a negative impact on residents: on their willingness to disclose their own status, on community morale, on their desire to participate in community activities.

**Impact of AIDS on the resident**

HIV status unknown	HIV status positive	Early illness	Severe illness	Final illness and death
None	Stress	Increasing possibility of default	Prolonged defaulting	Eviction and homelessness
	Stigma	Decreasing participation	Neglect of children	Orphans
	Alienation and rejection	Children stay home	Possible eviction	Increasing poverty
	Breakdown of social cohesion			

**Impact on staff**

When an individual staff member’s HIV status is unknown, no impact can be identified. When a staff member’s HIV+ status is known, the person is, like anyone, under great strain around issues of disclosure and stigma. Once disclosure is made to other staff, there may be a decrease in staff morale, and insecurity about the institution’s expectations of both the infected staff member and other staff members.

It is at this point that it becomes apparent that a human resource policy dealing specifically with HIV/AIDS is needed. Staff members are likely to have concerns about:

- avoiding infection
- protection from discrimination
- a safe working environment
- job security
- promotion and training opportunities
- equal access to employee benefits
- confidentiality

In the stages of early illness and severe illness there is likely to be increased absenteeism, and as severity increases this will become more sustained. There will concurrently be a decrease in administrative capacity and thus increasing pressure on management and staff to make up the shortfall.

Once the person has progressed to the final illness and then dies, the institution will require replacements and retraining. Staff trauma at the loss will lead to a short-term decrease in productivity as they mourn the loss of their colleague.

### Impact of AIDS on the staff of the social housing institution

HIV status unknown	HIV status positive	Early illness	Severe illness	Final illness and death
None	Stress	Increasing absenteeism	Sustained absenteeism	Replacement and retraining
	Stigma	Decreasing administrative capacity	Possible job loss	Staff trauma
	Alienation and rejection	Increasing pressure on management		Decrease productivity
	Break down of social cohesion			
	Decrease in staff morale			

## The enabling environment

### Disclosure, privacy, and confidentiality

Disclosure, privacy, and confidentiality are controversial issues that speak to the heart of the culture of secrecy and stigmatization that surrounds HIV/AIDS.

Disclosure is making public one's HIV+ status. In the workplace and in communities (including SHIs), people may not be forced to reveal their HIV status. When an individual has been tested for the virus, the result of the test is information only for the individual and may not be made known to anyone by the testing agency. Disclosure in the current climate often results in being ostracized from one's community. Thus people are both reluctant to make their status known and under strain when (if) they eventually do.

The government's present HIV/AIDS/STI strategy affirms that 'confidentiality and informed consent with regard to HIV testing and test results shall be protected'. Human rights is defined as a priority area, and recommendations aim to create campaigns around openness and the acceptance of people living with HIV/AIDS (PWAs), and to develop policy that protects the rights of all people infected with HIV/AIDS. The recommendations also aim to monitor human rights abuses, and develop ways to ensure that abuses are addressed. Specifics for monitoring whether people are feeling more comfortable and secure about disclosing include the number of voluntary counselling and testing (VCT) clients, the number of homeless children (indicating the capacity of society to care for AIDS orphans), and the number of people 'coming out' as infected.

Maintaining confidentiality and privacy, while simultaneously encouraging openness and acceptance, requires a fine balance. SHIs are communities in which the sensitivities around these issues can be observed. They present opportunities for spearheading activities that put this fine balance into practice.

### The policy environment

As a broad policy approach, HIV/AIDS does not feature in any significant way in housing policy, nor is housing considered in the present HIV/AIDS strategy.

In housing policy this is evidenced in the lack of responsive changes made by the national Department of Housing and provincial departments to the current crisis. None of the policy directives issued recently by the national department have addressed HIV/AIDS directly. HIV/AIDS is also not mentioned in the National Housing Code. The department has paid little attention from the policy point of view to the social, health, and cultural environments in which housing developments take place. Although the Department of Housing is currently addressing this gap through a range of research initiatives, nothing has transpired at a national level that would provide support to an SHI as it begins to deal with the crisis.

Policies that address the impact of HIV/AIDS are being developed at provincial level in KwaZulu-Natal and Gauteng, in spite of the absence of specific national policy. These concentrate on the plight of orphans and the crisis in caring for them in relation to title deed regulations and finding suitable shelter. It is unclear whether these policies have translated into definable programmes of action. People infected with and affected by HIV/AIDS are placed in the 'special needs' directorate. Added to this, the responses do not account for the urgency that faces PWAs: often their 'disability' is short-lived, as it comes in the concluding stages of the disease.

### **The social housing environment**

The figure illustrates the broader social housing environment in which SHIs operate. The institutional support upon which SHIs are able to draw is predominantly on the financial side of operating low-cost rental housing. There is little available support for addressing the social aspects of social housing. Certainly, none of the institutions in the figure have developed a response to HIV/AIDS. Neither the training materials offered by the Home Loan Guarantee Company or the Social Housing Foundation, nor the programmes funded by donors, nor any of the other interventions these institutions spearhead, deal with HIV/AIDS. At most, SHIs can rely on the efforts of other SHIs, and most look to the Johannesburg Housing Company for an indication of how to respond to HIV/AIDS. While the National Association of Social Housing Organizations has the potential to facilitate this interaction, it is a very young and capacity-limited organization.

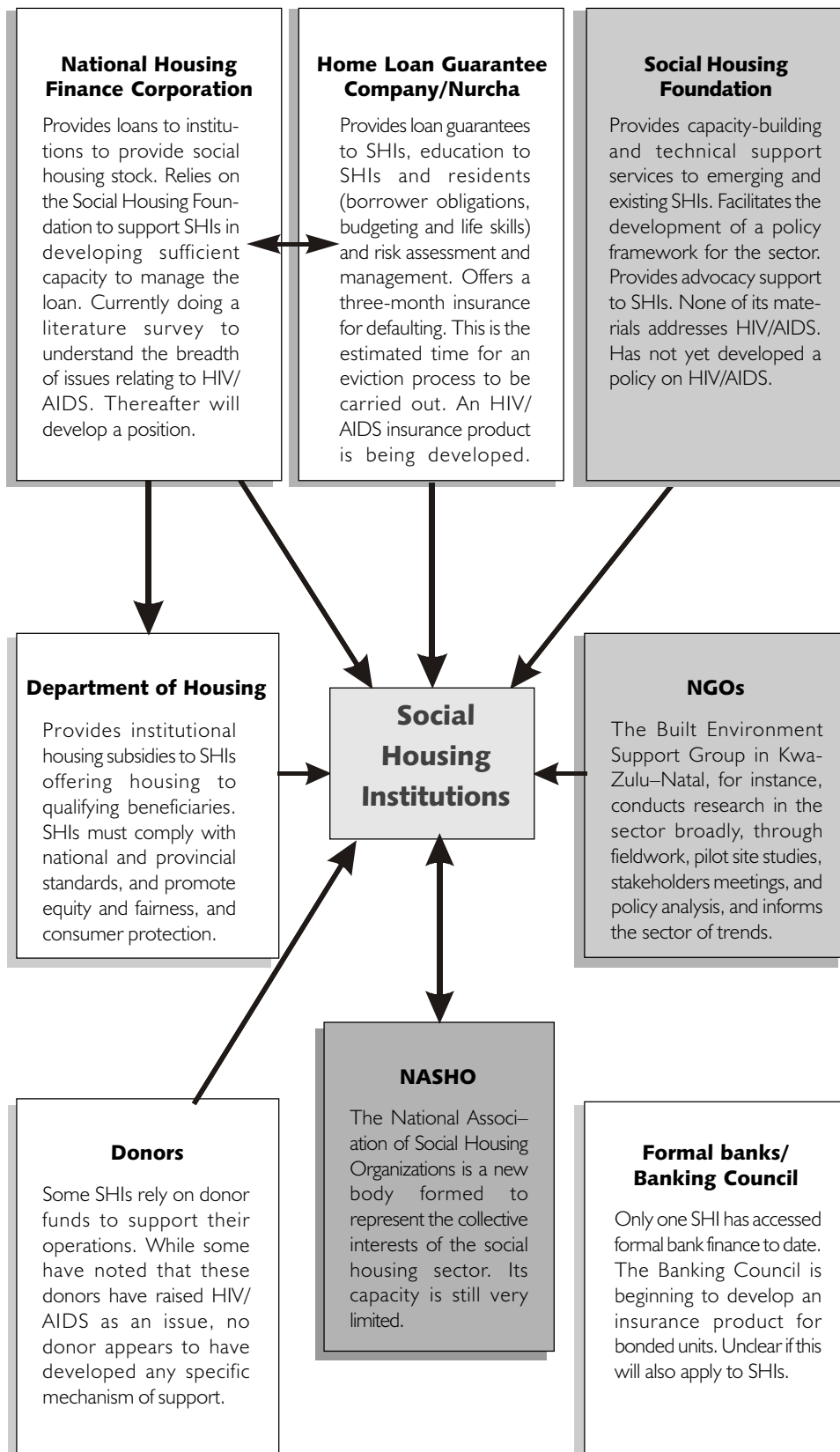
### **Legislation**

The enabling environment is critically framed by legislation that governs the affairs of SHIs, including:

**Constitution of the Republic of South Africa Act 108 of 1996:** The Constitution is the supreme law of South Africa, and overrides all other laws. Every person and organization in South Africa must operate within the bounds of the Constitution. Central to the Constitution is what is known as the Bill of Rights. This includes various clauses relating to the rights of individuals in South Africa. The following clauses are relevant:

- Section 9(4): 'No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3)' (including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth).
- Section 10: 'Everyone has inherent dignity and the right to have their dignity respected and protected.'

## The social housing environment



- Section 26: '(1) Everyone has the right to have access to adequate housing. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right. (3) No one may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances. No legislation may permit arbitrary evictions.
- Section 28: '(1) Every child has the right – (c) to basic nutrition, shelter, basic health care services and social services'.

**Housing Act 107 of 1997:** The Housing Act provides for the facilitation of a sustainable housing development process, and lays down general principles applicable to housing development. Among the principles, fairness and equity, and sustainability are particularly important.

**Alienation of Land Act 68 of 1981:** The Alienation of Land Act sets out the requirements for instalment sale agreements.

**Co-operatives Act 91 of 1981:** The Co-operatives Act sets out the requirements for housing co-operatives, which in terms of the Act operate as 'trading co-operatives'. The Act is currently being redrafted by the Department of Trade and Industry. It is not clear which, if any clauses apply to how an SHI might respond to the issue of HIV/AIDS.

**Labour Relations Amendment Act 12 of 2002:** The Labour Relations Act sets the terms and conditions for employers and their employees. It sets standards for human resources management.

**Prevention of Illegal Eviction from and Unlawful Occupation of Land Act 19 of 1998:** Known as PIE, this Act governs the process of evictions. It is significant in that a recent High Court ruling established that rental tenants were equally protected by its provisions. This would mean that if a tenant had been resident in an SHI for over six months, they could only be evicted if such an eviction were considered 'just and equitable' by a court of law, and if alternative accommodation was available. The incapacity of the existing service network as it applies to HIV+ families would suggest that such accommodation is not available. This would mean, in principle, that the SHI would not be entitled to evict a non-paying resident if that resident was HIV+ and needing additional care. The Department of Housing is currently seeking legal opinion on the matter.

## **The health and social services sector's responses**

### **The primary health care system**

In 1994, the 'National AIDS plan' was developed. Locating this policy in the Department of Health has resulted in a strong emphasis on the health aspects of the disease. Neglecting the necessary acknowledgement of the social and economic impacts on households has retarded efforts to mainstream responses to the epidemic and to provide proactive interventions from other departments.

Since 2000, there has been an increasing realisation that the broader social impacts of the epidemic require a broader policy and multi-departmental approach. Moves in this direc-

tion are noted in the present HIV/AIDS/STI strategy: the departments of education, social development, and labour feature as subsidiary partners with the Department of Health. However the policy remains health-centred rather than more broadly developmental, resulting in a strongly bio-medical and behavioural change approach. The key focus areas in this strategy are:

- prevention
- care and treatment
- monitoring, research, and surveillance
- human rights

These health-oriented intervention strategies are not easily compatible with the focus and mandate of other departments. It should be noted, though, that the departments of education and social development are increasingly focussing on the impact of HIV/AIDS in their policies. Programmes in provinces and at local (delivery) levels are still experiencing great challenges as the epidemic increases. Efforts to develop inter-departmental campaigns to manage prevention, treatment, and care have failed to make significant impacts.

The figure illustrates the services within the primary health care system that should be available to persons affected by HIV/AIDS. In principle, a person should be able to visit their local primary health care clinic, and, depending on their status, receive these services.

Unfortunately, the above belies the capacity constraints that exist at a local level.

#### Primary health care reponse to HIV/AIDS

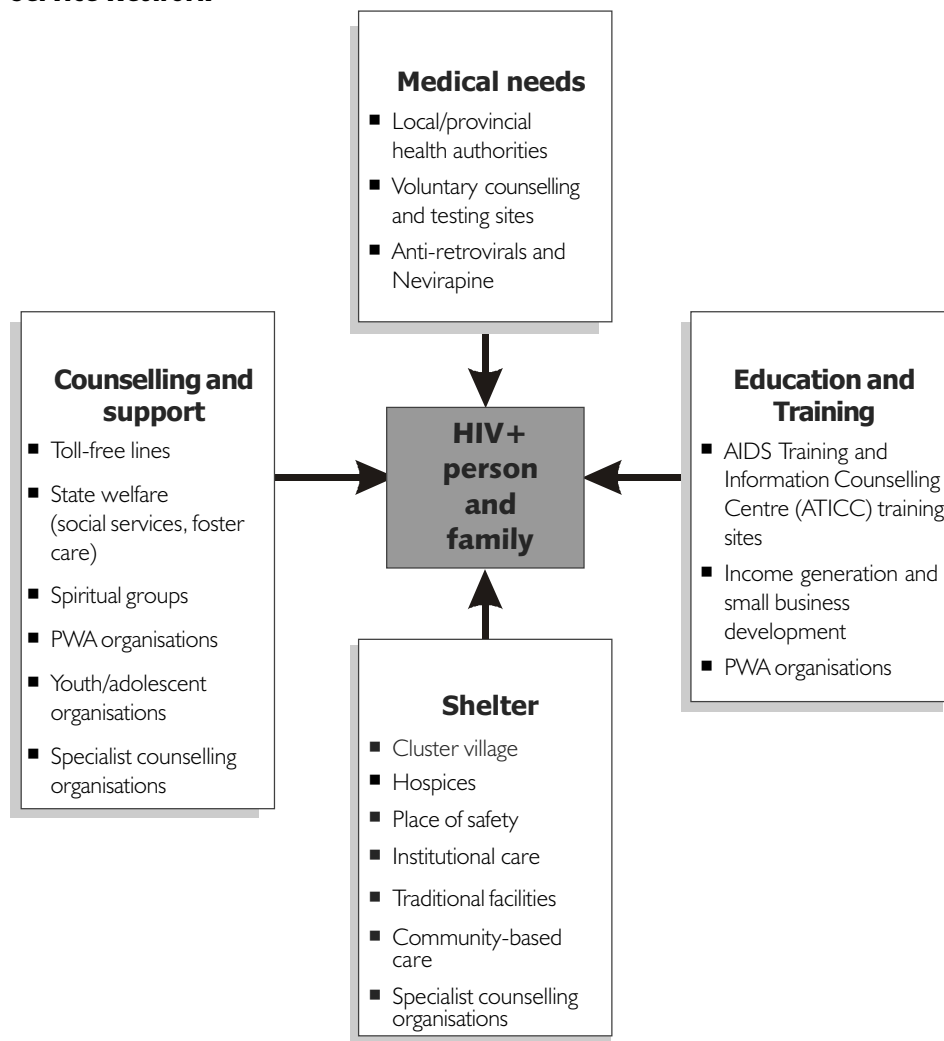
HIV status unknown	HIV status positive	Early illness	Severe illness	Final illness and death
Prevention programme	Prevention	Wellness management	Referral: to a hospice/home-based care/social services	Family support
Voluntary counselling and testing	Counselling	Treatment of opportunistic infections		
Awareness raising initiatives	Emphasis on building support system			
	Mother-to-child-transmission prevention			

In a study done for the Gauteng Department of Health and the Health Systems Trust by the Centre for Health Policy, it was found that services are not equally accessible in all clinics across Gauteng province. Those that are available are strained, and in many instances service providers lack the detailed knowledge necessary to undertake their roles effectively. It is unlikely that the remaining eight provinces are any better capacitated to deal with the epidemic.

**Capacity in the service network**

Beyond the primary health care system, a broader services network has emerged in response to the demand. This network comprises NGOs, CBOs, church organizations, and other facilities. The figure illustrates the services that are available.

**Service Network**



Notwithstanding the seeming proliferation of support services, lack of awareness of them is high among the SHIs interviewed. In addition, the services are accessible only in terms of certain conditions:

**Type of support:** Each of them offers different services to individuals or families at different stages of the disease. Each has different eligibility criteria. Hospices, for instance, only admit individuals who are terminally ill, having reached full-blown AIDS. Their families are not accommodated. The emphasis of the various education and training initiatives is on assisting organizations (such as an SHI) to develop sufficient capacity to be able to take on the training function independently. They do not have the capacity to enter into an outsourcing arrangement for the SHI.

**Scale of support:** Most of these interventions tend to be localised and small-scale, and often rely on community members' voluntary efforts (trained and untrained). Given the downscaling of government-funded institutional facilities (most institutional facilities have been cut by up to half), there are increasing demands on these resources and services. There are very few cluster villages – only one in Gauteng and possibly two in KwaZulu-Natal - and these are full, unable to accommodate additional persons unless one of their existing residents dies.

**Ability to scale up services:** The voluntary and independent funding nature of these services limits large-scale replicability.

**Funding:** While additional funding may be obtained from donors or a membership base (as in the case of churches), neither of these have the guarantee of sustainability. Consequently, initiatives rise and fall with the availability of funding.

**Administrative capacity:** Even when additional funding is raised to increase the scope (geographic and project-based) of these initiatives, the corresponding administrative and management capacity may not support such expansion.

As the disease progresses, determining eligibility criteria becomes very complex for SHIs, increasingly so when it may mean that families are separated. This has implications for secure tenure for children in particular. As orphanages have been halved in most provinces, increasing pressure is brought to bear on these alternative services. Voluntary, community-based work done by many women in their communities is a service at risk of collapsing without appropriate remuneration and ongoing training and support.

Given the scope of the epidemic, the capacity of the service network to respond to all those somehow affected is extremely limited. While a range of service providers does exist, and while among them they provide a vast range of services, they are generally already operating at capacity. The existing health and services infrastructure, as it is designed to accommodate HIV/AIDS, lacks the capacity to meet the existing demands that are being placed upon it, much less the increased demands that could be expected if an SHI were to become aggressive in its referral strategy.

While there seem to be many options for alternative housing for HIV+ people and their dependants, in reality there are long waiting lists at most institutional facilities. Given the time-linked nature of the effective management of HIV/AIDS, this does not serve the interest of HIV+ people and their dependants. On the whole, the current environment includes no shelter-specific option for affected families. Shelter for HIV+ people is available only in terms of the broader care requirements of that person, and this is only available on a temporary basis. **Nothing exists to accommodate households who cannot afford to continue with their rental payments as a result of their HIV status.**

# Part three: Proposals and the way forward

## Section 5: Proposals

### Summary of the findings

Research objectives	Research findings
1. To determine the level of awareness and possible stigmatization of HIV/AIDS issues in SHIs and amongst their residents.	Fourteen SHIs were interviewed. While many are aware of the prevalence of HIV/AIDS in society, few have associated this awareness with what might be the case among their resident and staff populations. Levels of stigmatization are presumed rife, though SHI staff have had few, if any, discussions either with residents or staff. Many SHIs expressed a need to learn how to talk about HIV/AIDS, as a way to avoid stigmatization.
2. To determine the presence/absence of HIV/AIDS mitigation activities/responses and education.	Very few SHIs have developed a response to HIV/AIDS. Only one SHI has developed a HIV/AIDS policy. A few SHIs have developed awareness programmes. Most SHIs respond on an <i>ad hoc</i> basis to problems that immediately present themselves, if they respond at all.
3. To determine the extent to which the epidemic is being addressed in terms of its effect on policy and planning for new social housing opportunities within the specific SHIs.	A few SHIs are considering the risk implications of the epidemic, and in this regard are investigating insurance options. A few other SHIs have considered the implications of HIV/AIDS on the design of their stock, or the need for special facilities, such as orphanages. All of these plans are still in their development stages, however.
4. To generate a combination of possible options and interventions for SHIs to engage with both mitigation activities and educational opportunities, and policy options for dealing with all levels of the HIV/AIDS epidemic.	A range of SHI and sector-based interventions are proposed. These relate to awareness, support, and risk management interventions, as well as the need to draft a specific policy that responds both to resident and human resources needs. At present, no SHI has addressed the issue of HIV/AIDS in the workplace.

Social housing and adequate shelter has an important role to play in a cross-sectoral response to the HIV/AIDS epidemic. While acknowledging the right to housing, the current policies and programmes have generally not served as a route out of poverty. When HIV/AIDS draws on already scant household resources, its impact is seen at many levels: decreased incomes, increased vulnerabilities, and increased inequalities. The disease is contracted and spread in places where people live with low job security and high unemployment, high levels of violence (domestic and external), poor infrastructure and social services (health and social development), and poor education. These exacerbate the impact of the disease as well as people's ability to survive.

As the most significant social condition in South Africa at present, it is imperative that policy measures respond to the virus in a way that takes cognisance of its most immediate impact in the places where people live and work. Here building social cohesion, inclusion, and equality are guiding principles for practical pro-poor responses that will not overburden already strained SHIs.

## **Defining the scope of responsibility**

HIV/AIDS is a national crisis. Institutions that have been established to address the needs arising from the crisis are struggling under the growing load. It is within this context that SHIs must decide what their role and responsibility is. It is clearly a difficult decision to make.

A few factors impact upon the decision:

- legal responsibilities
- mandate of the SHI
- contextual issues
- capacity considerations

### **Legal responsibilities**

At the most basic level, SHIs are bound by the Constitution. Thereafter, various other housing-related legislation applies and has relevance to how an SHI chooses to respond to the issues of HIV/AIDS:

- Housing Act 107 of 1997
- Alienation of Land Act 68 of 1981
- Co-operatives Act 91 of 1981
- Labour Relations Amendment Act 12 of 2002
- Prevention of Illegal Eviction from and Unlawful Occupation of Land Act 19 of 1998.

The above legislation sets specific minimum requirements for how SHIs should engage with their residents and their staff. It would appear that some SHIs are failing to meet even

these minimum requirements. SHIs should consider the implications of the above legislation in terms of:

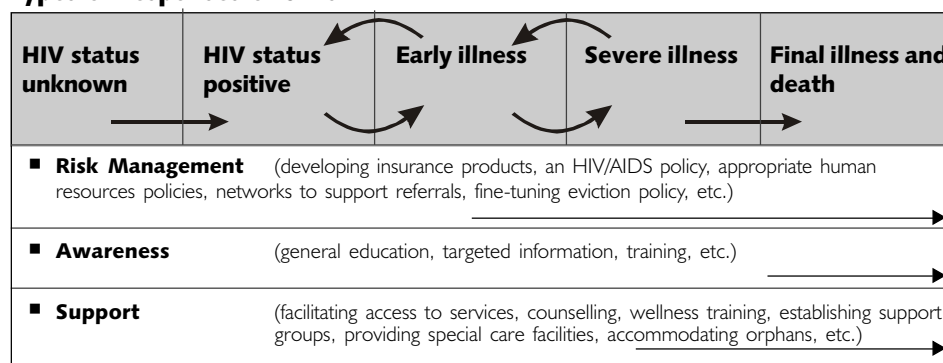
- the tenure they offer (instalment sale vs. rental)
- their current default management and eviction policies and procedures
- their lease agreements
- their human resources policies

**Mandate of the social housing institution**

The SHI’s specific mission and objectives must frame the decision it makes in terms of how it responds to HIV/AIDS and the extent of that response. An SHI may choose to focus its efforts on any one of the following types of interventions: risk management, awareness raising, and support (each of these, to varying degrees).

At different stages of the life of a person with HIV/AIDS, different types of interventions become relevant.

**Types of responses of SHIs**



The extent to which an SHI pursues one or more of these interventions will largely be determined by the mandate of the organization and at which point the SHI seeks to refer the individual to another service provider. At the very least, a prudent SHI will undertake the risk management interventions to minimise the risk to the SHI of having residents who are HIV+ but not yet posing a problem in terms of non-payment. Other SHIs may elect also to undertake awareness-type interventions, possibly as part of their risk management strategy. Still other SHIs may feel it is within their mandate to provide more extensive forms of support, from facilitating residents’ access to externally provided services to providing such services themselves.

An assessment of the SHI’s overall mandate should in all likelihood also be considered within the context of the definition of social housing.

**Contextual issues**

The type of tenure, whether instalment sale, rental, or co-operative, has specific legal implications. The type of housing, whether it involves free-standing units, flats, or townhouses, might also have an impact. Inner-city conversions, for instance, would not have the space opportunities that a new-build development might have. Walk-ups would be

less able to accommodate people with HIV/AIDS than single-storey dwellings. A risk assessment of the context in which the SHI operates would begin to identify the issues that should be considered.

### Capacity considerations

An SHI's capacity to respond is fundamentally tied to its human resources and financial capacity, as well as the funding capacity (and its sustainability) that exists in the immediate environment. This assessment should not be taken lightly. Based on the interviews, all SHIs have insufficient capacity to respond appropriately to HIV/AIDS. The other pressing crises that they face have the impact of narrowing their vision to focus on issues that immediately present themselves. In this sense, SHIs are unable to think beyond their narrow scope of affairs.

### Potential interventions

On the basis of how SHIs define the scope of their responsibility, they might undertake any number of initiatives independently. These interventions can be applied both in terms of the SHI's resident population as well as its staff and board.

#### Potential interventions for SHIs

	HIV status unknown	HIV status positive	Early illness	Severe illness	Final illness and death
<b>Risk management</b>	Draft HIV/AIDS policy	Support planning for death	Lobby for appropriate and affordable treatment	Facilitate access to anti-retrovirals	Establish direct referral relationships with foster homes and orphanages
	Draft SHI HIV/AIDS plan	Facilitate discussion to confirm succession arrangements and care for possible orphans	Facilitate access to primary healthcare, medication and mobile nurses	Contact next of kin	Send children to next of kin
	Mainstream SHI policies: human resources, eviction	Identify next of kin		Refer to appropriate home-based care	
	Financial modelling for insurance	Financial management training: one-on-one budgeting to include rising health cost			
	Consider staff benefit structure: insurance/death benefit	Implement savings plan			

	HIV status unknown	HIV status positive	Early illness	Severe illness	Final illness and death
<b>Awareness</b>	Identify local HIV/AIDS networks	Awareness raising workshops	Facilitate access to wellness management training	Facilitate access to hospices other medical service providers	
	Train staff to be able to respond appropriately	Publicize existence of network			
	Facilitate access to voluntary counselling and testing sites	Promote voluntary counselling and testing disclosure			
	Mainstream education materials	Facilitate life skills training			
	Facilitate access to information on funeral policies and death benefits	Provide education on anti-retrovirals and treatment			
<b>Support</b>	Provide condom dispensers	Facilitate access to counselling education, and information	Identify immune-boosters and facilitate access	Encourage resident volunteer home-based care providers	Palliative care
	Facilitate sustainable income generation	Facilitate support group		Facilities for palliative care	Establish orphanage to accommodate children activities
		Facilitate income generation activities			Death benefit to the bereaved
		Welcome food garden NGOs to promote nutrition			

Ideally a policy is created in order to clarify the SHI’s position and practices in relation to staff and residents who are infected with or affected by HIV/AIDS. In carrying out the above, the policy should:

- launch prevention programmes and address wellness management
- provide clear guidelines and a legal framework for managing HIV/AIDS in the workplace and the community
- foster a culture of acceptance within which staff and residents can be open about their status without fear of rejection or bias

- promote an environment that protects the rights of infected individuals while simultaneously allowing PWAs to work under normal circumstances for as long as they are physically capable
- provide a framework for action (especially regarding incapacity, dismissals, compensation, and grievance procedures for staff; or regarding non-payment, illness management, child care, succession, and other issues for residents).

These ideas are by no means exhaustive of the types of interventions that SHIs could either spearhead or support. Local conditions should serve as a guide for appropriate responses.

## **Responding as a sector**

The fact of the current HIV/AIDS crisis in South Africa is that SHIs are at the end of a long line of potential service providers that have failed affected persons, either because of their non-availability or because of the extent to which they are overstretched, unable to meet the growing demand. Residents who are somehow affected with HIV/AIDS have no one else but the SHI to depend upon when they find they are in need. SHIs are overstretched themselves, however, having to address a range of socio-economic issues that extend beyond HIV/AIDS. In seeking to maintain high rent collection rates while trying to manage the overall business, SHIs are falling short of meeting their residents' needs.

Clearly, SHIs cannot operate in isolation. A number of SHIs interviewed suggested the need for a comprehensive but generic policy on HIV/AIDS that they could apply in their individual contexts. These SHIs were looking to the Social Housing Foundation to provide such a policy. The figure looks at the range of interventions in the social housing sector.

**Potential social housing sector responses to HIV/AIDS**

<b>Generic focus</b>	<b>Social Housing Foundation: Generic, model policies</b>
	<ul style="list-style-type: none"> <li>■ Generic plan.</li> <li>■ Review of legislation and policies to identify relevant issues; lobby government for necessary changes.</li> <li>■ Develop national and provincial level networks with HIV/AIDS service providers.</li> <li>■ Develop training programmes for SHI staff.</li> <li>■ Develop generic training materials for residents.</li> <li>■ Review standard lease agreements and will formats</li> <li>■ SHI discussion forum/support group for CEOs.</li> <li>■ Represent SHIs' interests to national and provincial government</li> <li>■ Consider proactive response to non-availability of anti-retroviral drugs: revolving fund</li> <li>■ Consider insurance options: hardship cover</li> </ul>
<b>Operational</b>	<b>Social housing institution: Operational policies and procedures focus</b>
	<ul style="list-style-type: none"> <li>■ Draft HIV/AIDS policy; amend existing policies</li> <li>■ Mainstream HIV/AIDS in all SHI activities</li> <li>■ Train staff members to deal with HIV/AIDS</li> <li>■ Identify local network and forge relationships; facilitate resident access to their services</li> <li>■ Offer specific benefits: death cover</li> <li>■ Facilitate NGOs' access to resident group: implement food gardens, income generation activities, etc.</li> <li>■ Offer specific, individual training, targeted at points in the progression of HIV/AIDS: awareness, financial management, living with HIV/AIDS, wellness, use of medication, etc.</li> </ul>
<b>Grassroots focus</b>	<b>Residents: Grassroots, micro focus</b>
	<ul style="list-style-type: none"> <li>■ Participatory initiatives such as support groups</li> <li>■ Voluntary initiatives such as training of home-based care volunteers</li> <li>■ Promote voluntary counselling and testing and disclosure</li> <li>■ Initiate savings mechanisms: burial society, rainy day fund</li> <li>■ Establish crèche/youth centre to care for children whose parents are ill</li> <li>■ Hold resident discussions</li> </ul>

## Section 6: The way forward

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### The sector's response to the research

This report was presented to an *imbizo* (workshop) organized by the Social Housing Foundation and held in Johannesburg on 27 September 2002 (see annexure 3). Over 50 people attended – from SHIs, support organizations, local municipalities, provincial and national government, financial institutions, and other bodies. On the whole, participants agreed with the findings of the research as presented in this report.

The *imbizo* agreed on the following:

- **Awareness:** HIV/AIDS is a serious issue with potentially catastrophic implications for SHIs in terms of their long-term sustainability (both financially and socially), and their overall ability to carry out their individual mandates within the broader framework of how social housing is defined in South Africa. Knowledge about the epidemic, from rates of prevalence among residents and staff, through to how to discuss it, is limited.
- **Existing response:** Insufficient attention has been given to the issue of HIV/AIDS. Responses were either *ad hoc* and reactive, or proactive but not yet finalized. To date, planning gave insufficient attention to the reality of HIV/AIDS. SHIs are at the very least responsible for developing some response, however extensive or limited.

In considering a way forward, the *imbizo* expressed specific concern about the following issues:

- **The balance between financial sustainability and responsibility** to one's residents - How should SHIs define their role?
- **The role of other stakeholders and service providers**, including government – How could SHIs ensure that others carried out their roles in awareness raising, prevention strategies, and support measures?
- **The need to work as a sector**, notwithstanding the current lack of co-operation amongst SHIs – How might SHIs organize themselves so that they could draw on their mutual strength rather than act in isolation, as was currently the case?
- **The enormity of the challenge** – What are the basic ingredients for an appropriate, humane, and sustainable response to HIV/AIDS by SHIs, given their capacity constraints and the relatively limited experience they have had with the epidemic to date?

The *imbizo* agreed that the above issues required a sustained debate in which all factors were considered. Consequently, it was recommended and agreed that a special task team be urgently convened to carry the issues forward, develop a programme for action, and implement the proposals emanating from the research.

## **An opportunity for the social housing sector**

SHIs must by their very nature be at the forefront of developing appropriate responses to the impact that HIV/AIDS does and will have on their business. While all institutions involved in the financing of housing must respond to the risk of HIV/AIDS, it is the essence of what social housing is that differentiates SHIs and puts them perhaps at greater risk than their more commercially-driven counterparts. Where a landlord may regard the incidence of non-payment in isolation and respond by instituting eviction procedures, an SHI would consider the broader factors impacting upon such non-payment. SHIs also rely on their residents to participate as active members in the local community, and as such have a responsibility to meet those residents' needs from a broader, social perspective. Households affected by HIV/AIDS, either directly or indirectly, remain an integral part of the community upon which the SHI relies. As such, they are more than just debtors, and their ability to pay is part of a bigger picture. The SHI cannot afford to ignore their broader circumstances.

The consequence is that SHIs and the sector as a whole have the opportunity to set the standard for a compassionate response to the HIV/AIDS epidemic. SHIs are also uniquely appropriate to deal with the transitional nature of people living with and affected by HIV/AIDS, as well as those who are at the mature stages of the disease.

## **Towards a plan of action**

The authors of this report concur with the outcome of the HIV/AIDS *imbizo*. This report, and indeed the *imbizo* itself, contain a vast number of detailed recommendations. Each could form the basis for its own report and implementation plan. It is therefore recommended that the Social Housing Foundation establishes a task team to work through the recommendations in this report and arising from the *imbizo*, and develops a plan of action that includes short-, medium-, and long-term interventions.

### **Short-term (immediate) interventions**

- Distributing this report to all stakeholders throughout the social housing sector, irrespective of whether they have yet begun to deliver stock
- Undertaking a quick review of all education material, and mainstreaming issues of HIV/AIDS within them
- Reviewing the legislative implications associated with HIV/AIDS and the experience of the disease in the social housing sector
- Facilitating a discussion regarding the scope of responsibility for SHIs generally, and how this might be differentiated by circumstance
- Developing a generic policy on HIV/AIDS and SHIs, and distributing this throughout the sector for comment.

### **Medium-term (three to six months) interventions**

- Finalizing the HIV/AIDS and SHIs policy
- Facilitating SHIs in forging networks with local service providers and support groups

- Developing specific education and training materials that deal with HIV/AIDS
- Establishing a training corps to offer targeted HIV/AIDS training to SHIs
- Identifying operational interventions that SHIs can undertake to complement a health sector wellness support mechanism
- Supporting SHIs in implementing disclosure programmes

### **Long-term (6-18 months) interventions**

- Developing an approach towards the availability of anti-retroviral drugs
- Developing a response to the possibility of orphans within SHIs
- Supporting SHIs as they begin to implement awareness and prevention programmes
- Lobbying the wider government sector for support in key areas (availability of anti-retroviral drugs, improved access to primary health care services, availability of palliative care facilities, etc).

## **Conclusion**

SHIs are currently faced with a choice. They can choose to do nothing and risk having both their financial and social sustainability threatened as the disease progresses among the infected members of their resident population and staff. Or they can begin to think proactively around how they might support their residents' and staff's productive lives while they live with the disease.

Many of the interventions proposed in this report are simple and cost-effective, requiring very little in the way of financial resources. A response need not involve substantial organizational change and additional resources: a simple refocus of management to wrap-around, mainstream services, could extend residents' lives considerably. Notwithstanding their very real capacity constraints, born of the difficult circumstances in which they all operate, SHIs do have the capacity to be trailblazers, providing the standard for a humane approach.

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# Annexure 1

## Social housing institutions interviewed

Name	Abbreviations	CEO	People interviewed	Date
<b>Gauteng/Mpumalanga</b>				
The Johannesburg Housing Company	JHC	Taffy Adler/Paul Jackson (acting)	Lindi Malinga: Community Development Officer	20 Aug
Cope Housing Association	Cope	Sipho Simelane	Sipho Simelane	28 Aug
Greater Germiston Inner City Housing Corporation	GGIHC	Ronalda Fisher	Ronalda Fisher, Mathilda Rafapa, Letting Officer	19 Aug
Semag Housing Corporation	Semag	David Morema	David Morema	3 Sept
Greater Middelburg Housing Association	GMHA	Thomas Ntuli	Meisie Mlombo: Accountant, Anver Osman: Property Manager	30 Aug
Yeast City Housing	YHC	Stephan de Beer (acting)	Stephan de Beer, Josephine Stuurman: Office Manager, Alson Ngoveni: Project Co-ordinator	28 Aug
Simunye Housing Association	Simunye	Ludwick Sebetola (Chairperson)	Ma Ramafalo, Patience Mqungwana, Unity Nakoki, Ludwick Sebetola, Alfred Ramafalo	10 Sept
Vukuzakhe Housing Association	Vukuzakhe	Andy Briley (Project Manager)	Stephina Tjipana, Esson Dlomo, Chris Muluke	10 Sept
Nkhesani Housing Association	Nkhesani	Frans Sebothoma (Chairperson)	KM Mogohluana, Frans Sebothoma, Glory Nkwe	10 Sept
<b>Eastern Cape</b>				
Housing Association East London	HAEL	Patrick Lemmens	Patrick Lemmens, Gafee Vengadajellum: Client Service Manager	21 Aug
<b>Western Cape</b>				
Cape Town Community Housing Company	CTCHC	Mervyn Bregman	Mervyn Bregman	26 Aug
Social Housing Company	SOHCO	Monica	Zohra Ebrahim: Chairperson of the Board, Otto Holicki: Acting Project Manager	26 Aug
<b>KwaZulu- Natal</b>				
First Metro Housing Company	FMHC	Ian Wheeler	Ian Wheeler	29 Aug
Shayamoya Housing Association	SHA	Rev. John Mangoato	Nhlanhla Ndlovu: Administrator, (Chairperson) Soya Govender: Director (Administration), Jabu: resident, and health care volunteer, Cindy Zulu, Zodwa Mgandela, Alice Methusi: community health workers	29Aug

# Annexure 2

## Contact list:

### HIV/AIDS Service Provider

As part of the Social Housing Foundation's study of current or planned responses to HIV/AIDS within the social housing sector, it became clear that in order to respond appropriately to the epidemic each SHI would require links with HIV/AIDS service providers. In addition to the numbers provided below, the South African Aids Directory is available in electronic format at [www.sahealthinfo.org/aidsdir](http://www.sahealthinfo.org/aidsdir) for more specialized requests.

You can contact the Social Housing Foundation on:

**Tel: 011 274 6200**  
**Fax: 011 642 2808**  
**Web: [www.shf.org.za](http://www.shf.org.za)**

### Toll-Free Numbers

These numbers offer the following services free of charge: telephone counselling, up to date HIV/AIDS information, and national referrals on a wide range of topics including, shelter and accommodation, addiction, employment, and medical and emergency services.

<b>AIDS Helpline</b>	<b>0800 012 322</b>
<b>National Youth Commission</b>	<b>0800 000 001</b>
<b>Childline</b>	<b>08000 55 555</b>
<b>Stop Women Abuse Helpline</b>	<b>0800 150 150</b>

## AIDS Training Information and Counselling Centres (ATICCs)

ATICCs offer a number of services related to HIV/AIDS, providing information, workshops, awareness talks, counselling, HIV testing, training for educators and counsellors, referrals, condom distribution, and resources centres.

Centre	Telephone	Fax	Street address	Province
AIDS Training Information and Counselling Centre JHB	011 725 6711/ 2	011 752 2579	17 Esselen St, Hillbrow Johannesburg	Gauteng
AIDS Training Information and Counselling Centre Plumstead	021 797 3327	021 797 3356	1 <sup>st</sup> Floor, Lady Mitchaelis Timour Hall Rd Plumstead	Western Cape
AIDS Training Information and Counselling Centre Durban	013 300 3104	013 306 9294	2 <sup>nd</sup> Floor, 9 Old Fort Place Durban	KwaZulu-Natal
AIDS Training Information and Counselling Centre East London	043 705 2620	043 743 9743	City Hall Department 30 Beaconsfield Rd, East London	Eastern Cape
AIDS Training Information and Counselling Centre Port Elizabeth	041 506 1415	041 506 1486	Brisler House 191 Main St, Port Elizabeth	Eastern Cape

## Lifeline

Lifeline is a national organization with regional offices that provide telephone counselling, information/education, face-to-face counselling (including trauma debriefing and rape counselling), and workshops on life skills, HIV/AIDS, communication skills, and related topics.

Centre	Telephone	Fax	E-mail	Street address	Province
Lifeline Johannesburg	011 728 1347 (crisis line) 011 728 1331 (office)	011 728 3497	llinejhb@iafrica.com	2 The Ave, Norwood	Gauteng
Lifeline Western Cape	021 461 1111 (crisis line) 021 461 1113 (office)	021 461 6400	lifeline@iafrica.com	56 Roeland St. Cape Town	Western Cape
Lifeline Durban	031 312 2323 (crisis line) 031 303 1344 (office)	031 303 1419	lnatal@mweb.co.za	38 Andrian Rd, Stamford Hill Durban	KwaZulu-Natal
Lifeline Port Elizabeth	041 585 5581 (crisis line) 041 585 8565 (office)	041 585 8565	lifeline@peisat.co.za	7 Cooper St, Central Port Elizabeth	Eastern Cape
Lifeline East London Port Elizabeth	043 722 200 (crisis line) 043 743 7266 (office)	043 743 7266	lifeline@peisat.co.za	7 Cooper St, Central Port Elizabeth	Eastern Cape

## Planned Parenthood Association of South Africa (PPASA)

The PPASA is a national organization offering reproductive health and sexuality education programmes (including HIV/AIDS), counselling, information and psycho-social support.

Centre	Telephone	Fax	E-mail	Street address	Province
Planned Parenthood Association of South Africa National Office	011 482 4601	011 482 4602	ppasa@wn.apc.org	31 Plantation Rd, Auckland Park, Johannesburg	Gauteng
Planned Parenthood Association of South Africa Gauteng	011 403 7740	011 403 2385	ppagau@wn.apc.org	11 <sup>th</sup> Floor, Traduna Centre 118 Jorrisen St, Braamfontein	Gauteng
Planned Parenthood Association of South Africa KwaZulu-Natal	033 394 2117	033 394 2275	ppakzn@wn.apc.org	29 Havelock St, Pietermaritzburg	KwaZulu-Natal
Planned Parenthood Association of South Africa Eastern Cape Region	041 487 2672	041 484 4083	ppaec@wn.apc.org	44 Green St, North End, Port Elizabeth	Eastern Cape
Planned Parenthood Association of South Africa Western Cape	021 448 7312	021 448 7320	ppawc@ppawc.co.za	12 Anson St, Observatory Cape Town	Western Cape

## Additional Resources

You can also use these numbers for referrals to local organizations in your area.

### National Association of People Living with AIDS (NAPWA)

NAPWA offers assistance to people who are infected and affected by HIV/AIDS, providing education talks, counselling and support groups.

**Tel: (011) 720 3349**

### AIDS Law Project

The Aids Law Project offers information on human rights, policy and advocacy.

**Tel: (011) 717 8600**

### Hospice National Office

Hospice is a national organization that cares for the terminally ill and offers support to individuals and their families. They also provide training on home-based care and bereavement counselling.

**Tel: (021) 531 2094**

# Annexure 3

## HIV/AIDS Imbizo

**Sunnyside Park Hotel**

**27 September 2002**

### Note for the record

#### Attendance

Name	Organisation	Telephone	Fax	E-mail
Beryl Unterhalter		011 646 7020		berylu@wol.co.za
Mteteleli Pobana	Afesis-Corplan	043 743 3830	043 743 2200 073 277 1372	mthe@wn.apc.org.za
Tanya Zack	ARP	011 486 3772 082 840 0710	011 486 3772	briannr@icon.co.za
Nina Saunders	BESG	031 260 2267	031 260 1236	Saundersn1@nu.ac.za
Zanele Nqabbeni	Buffalo Entrep Housing Assoc.	043 743 1305 082 654 9362	043 743 0213	bfcdt@iafrica.com
R Fisher	GGICHC	011 872 0319	011 825 1326	rfisher@ggichc.co.za
Margaret Fish	Cope	011 833 8535 083 453 4089	011 833 8536	Margaret@cope.org.za
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## Welcome

Odette Crofton (Social Housing Foundation) welcomed delegates to the HIV/AIDS imbizo. She explained that the day would cover two specific topics. In the morning, a presentation on recent research into the responses of SHIs to HIV/AIDS would be given. This would be followed by discussion. Following the lunch break, a presentation on research into a hardship cover would be given.

In her welcome, Georgina Jaffee (Rooftops) explained why Rooftops and the Social Housing Foundation were intent on addressing issues of HIV/AIDS as they impact upon SHIs and the social housing sector broadly.

### Responses to HIV/AIDS among SHIs

Kecia Rust, Sean Lotriet, Catherine Moat, and Xolani Kunene presented their research and findings to the meeting.

### Questions following first half of presentation

Following the first half of the presentation, during which the current status of SHIs' response to HIV/AIDS and the issues surrounding this was considered, many of the participants expressed a sense of being overwhelmed. The following comments were made:

- Josephine Stuurman (Yeast) suggested the establishment of a “special purpose” SHI that had the expressed mandate to take in orphans or other people somehow affected by HIV/AIDS. She said that as landlords, SHIs were put in a very difficult position – while feeling for their tenants, they were also responsible for the long-term sustainability of the institution. She asked how landlords should manage this challenge. Also, she noted that following the death of a family member, a household's income would be further diverted to pay for the funeral. Perhaps this could be planned for in advance.
- Shiraaz Fakir (Nurcha) noted that most of the SHIs are funded by primarily one institution, the NHFC. He asked: If they run into problems, what is the impact on that funder?
- Silas Diamond (NUM) raised the issue of affordability with respect to insurance. He asked: Can people afford rising premiums as prevalence rates increase?
- David Brand noted that 30 per cent of SHIs interviewed considered the impact of HIV/AIDS on their operations in terms of rental flows and governance issues. He said that the absence of a humane response was glaring. He noted that while most SHIs had suggested that they have conversations with their tenants, none had initiated the process.
- Ronald Fisher (GGICHC) agreed. She said that the issue of default was prominent because it was currently a crisis with which all SHIs were dealing, irrespective of

the prevalence of HIV/AIDS. She suggested that within the SHIs themselves, some form of training was needed so that management would be sufficiently equipped to pass on that message. She asked if the Social Housing Foundation was willing to help. SHIs had not even touched the concept of social yet, she said.

- Commenting on the practice of refer non-paying households to RDP houses, Nellie Agingu (Planact) asked if this was a real alternative given affordability constraints of the household to maintain themselves in that unit.
- Chris Lund (Johannesburg Trust for the Homeless) asked what the likely impact of HIV/AIDS was going to be on the demand for housing by 2010. Odette Crofton noted that a study on this issue had been undertaken by Kayamandi.
- A representative from the Sisters of Mercy emphasized that many of the problems raised were as a result of a lack of social security. She urged participants to advocate for a social security solution from the state.
- Duncan MacArthur (HLGC) raised the issue of the sustainability of SHIs given the high upfront costs they were incurring (high standards for development, etc.) and the impact this had on rental affordability. He argued that the sector had created a stressed affordability situation in terms of quality of stock – this had a significant impact on the loan requirements. He worried that the approach taken to date was exposing SHIs to too much risk, especially given the profile of their tenant population.
- Tanya Zack (Alexandra Renewal Project) raised the issue of stigma as it is expressed in Alexandra township. She said that notwithstanding the availability of funding for special needs housing and facilities, the community has been resistant to the construction of a “hospice” for fear of the truth this might expose. On the positive side, this meant that the community was embracing home-based care and community-based care as the response. She said that the ARP had acknowledged the need to name things differently. The same stigma applied to orphanages – these were rather being developed as “step-down facilities”.

## Reportback following participant discussion

Following the presentation of the consultants’ proposals, participants in the imbizo broke up into four groups. These groups discussed the issues raised, and then reported back to the plenary on their deliberations. Their comments are summarized below.

### Group one

#### **Duncan MacArthur (HLGC) reported for the first group:**

- Policy: SHIs have to decide where they sit in terms of their relationship with their tenants. Do they see the tenant as a customer? What is the legal basis for their relationship? If they offer rental stock, tenants become lessees. In this case, if the lessee fails to uphold the agreement, only option may be to evict in the event of non-payment.

- Crisis approach: Every tenant is subject to vulnerability – how does an SHI respond to a tenant affected by cancer, a car crash, TB, or other crises? Broadening the definition could be used as a way to de-stigmatize AIDS.
- The role of the SHI within the broader community: SHIs operate within a context, in which a range of social services might exist. SHIs should identify these services and make linkages in advance of a problem.
- Capacity of the SHI as a local stakeholder: SHIs have the capacity to develop a lobbying network. This was being developed in KwaZulu-Natal by BESC and the Shayamoya Housing Association, where SHA was being used as a “vehicle” for other things happening in the area.
- Design issues: If we are dealing with HIV in SHIs, SHIs should think of health care in design – wider corridors for wheelchairs, “sick beds”, smaller units, etc. Of course, this would have an impact on development costs.
- Community empowerment: The SHI community needs to be empowered – in this regard, the SHI’s board and management should play the role of catalyst in the empowerment process. It was suggested that this might be the beginning of a new relationship between the SHI and its tenants, and that the elusiveness of the “social” in social housing might be addressed in this way.

## Group two

### **Ronalda Fisher (GGICHC) reported for the second group:**

- National precedent: The group wondered what national DoH policy on the matter was. SHIs should not be required to reinvent the wheel.
- Policy development: In the development of local, SHI-specific policy, she argued that tenant bodies should be included in the process. This process could also be used as a tool with which to forge broader discussion among residents and management regarding issues of HIV/AIDS.
- Design: If units were designed around certain illnesses, their occupation could add to already existing stigma – residents would automatically be associated with the illness for which the unit was designed. She asked how the confidentiality of people would be protected in this case.
- Savings: As an alternative to insurance, upfront savings might be a possibility. Savings was more broadly applicable, even for households not affected by HIV/AIDS or another crisis. She suggested that an investigation into Nurcha’s savings structure and policy be undertaken in this regard. A savings programme would have to be coupled with an education programme so residents understood the need to participate.
- Crisis approach: HIV is only one of a number of crises affecting SHI tenant populations. These other crises should also be accommodated in a policy.
- Responsibility: Where does SHIs’ responsibility end? Who takes responsibility for the affected household once the SHI’s role is done? What happens to children who

are orphaned, or grandparents who have lost the children who once supported them? A broader safety net was critically required.

- Need for networks: SHIs are by their nature limited in capacity. For this reason, networking with other SHIs, local level NGOs, clinics, the municipality, and others was critical. This was also important so that SHIs could develop their understanding of and sensitivity to the issues surrounding HIV/AIDS. While there were many disparate initiatives relating to HIV/AIDS, even within the SHI sector, it was distressing that no one was talking to one another.

## Group three

### **Josephine Stuurman (Yeast City Housing) reported for the third group:**

- Networking: SHIs should develop a comprehensive network so that each can learn from the other. Links with neighbouring NGOs and CBOs were also important. Yeast City Housing, for example, draws on its sister group, Pretoria Community Ministries, to offer social programmes and activities.
- Beyond capacity: A mechanism for referrals was always necessary – even if an SHI were to develop special facilities as Yeast is proposing to do, it has to be able to deal with the possibility of becoming full. Indeed, the provision of special facilities might attract people specifically to the SHI. How should this be managed?
- Job creation: To support sustainability objectives, job creation projects should be established early on within the SHI. Yeast has bought a franchise to create jobs – using the stokvel concept – for its residents, even those who were very ill.
- Insurance: A worrying issue was the profit impulse of insurance companies. Rather a scheme should be developed whereby the mechanism pays for itself once it reaches scale. A fund established by all SHIs jointly might accommodate this goal.
- Social security: PWAs should be supported by a government levy charged on some regular item (petrol?).
- Home-based care: Options should be considered.
- Food gardens: SHIs should encourage the establishment of food gardens. These offer resident a cost-effective way of ensuring nutrition, thereby supporting their health and long-term productivity.

## Group four

### **Nellie Agingu (Planact) reported for the fourth group:**

- Emphasis on community development: SHIs should integrate themselves with their local communities and use a community development approach to address the HIV/AIDS crisis. In this regard, SHIs should start thinking about how they engage with social issues and concerns.
- Priority on payment: Non-payment is a national problem arising for a range of rea-

sons (unemployment, illness, etc.) HIV/AIDS is only one of the causes. The response to non-payment should therefore be broadened to address the range of crises beyond the current, single response of eviction.

- Risk management: SHIs should develop contingency plans in terms of their long-range planning.
- Education and awareness raising: SHIs should develop a comprehensive programme and not address it simply as a once-off issue.
- Holding others accountable: SHIs should involve other players, including government and specifically the health, social services and other departments. There was a sense that SHIs had not pushed these institutions or departments hard enough to get them to do their jobs. NASHO should be strengthened or consolidated so that it deals with government head on, on policy issues as well as on the redirection of government in terms of legislation.
- Indigent policy: SHIs should also lobby for this. The lottery could be used as a potential source. How do SHIs lobby to get their issues heard by these funding sources?
- Insurance: SHIs require tailor-made insurance or hardship cover. Might this be best designed internally?
- Donors and funding in the donor community: The funds that are being allocated are too limited to the provision of housing itself. They should also accommodate needs for HIV/AIDS education and other initiatives.

## Group five

### **Sekgametsi More (Malebo B.E.) reported for the fifth group:**

- Policy: This issue has to be tackled head on. Currently, both the Rental Housing Act and SHI policies empower us to evict if residents are unable to pay. Policies will need to be changed to accommodate PWAs and to allow SHIs to respond humanely.
- Right-sizing: The idea to refer people who cannot afford rental payments to RDP houses was supported.
- Need to establish committees that will be responsible to educate on HIV, insurance (also will help define needs in insurance – tailor made to specific needs). There should be an emphasis on assisting dependants to survive without the breadwinner.
- Network: SHIs should mobilize a network with other organizations and government departments – right now it seems to each SHI as if it is working in isolation. Yet, HIV/AIDS is affecting everyone. SHIs should make the social housing sector an example in the fight against HIV/AIDS.
- Social responsibility: SHIs should develop a fund to finance the building of hospices and orphanages to specifically cater for SHI residents affected by the pandemic.

## Group six

### **Irene Eastwood (Servcon) reported for the sixth group:**

- Policy: A standard, all encompassing, industry policy should be developed to guide various institutions. Specific implementation of the policy would then depend on the capacity of the SHI concerned.
- Relationships: The whole stigma/perception issue starts with relationships. The officials and staff in the SHI should be trained as people who deal with other people. Emphasizing the SHI as a caring environment will allow residents to feel comfortable about disclosure. This will help both with general awareness of prevalence, while also supporting the SHI's planning process.
- Insurance should be considered, notwithstanding the costs involved.
- Training of residents: Life skills training should be offered by SHIs. Within this, a specific section on the HIV/AIDS pandemic should be included.
- Role of government: SHIs need real support from government for their efforts to work. SHIs should lobby government to support policy on a national basis.
- Networking: SHIs should ensure that their tenants have an outlet for disclosure and support, even if such is not sought from the SHI itself. In this regard, SHIs should lobby with other NGOs and CBOs, clinics, and other bodies to ensure accessibility to their services by tenants.
- Building design: An easy, cost-effective way to accommodate frailty in building design should be developed.

### **Hardship cover fund for Cope Housing Association**

Stephen Jurisich (Quindiem Consulting) presented on the research that he had undertaken into a hardship cover for Cope Housing Association. The work had been funded by HFRP, and had been published in two documents (HFRP Occasional papers no. 6 and 7) in June 2002. He explained that the target of a hardship fund was based on two principles:

- That the intention was to provide benefits on loss of income or death due to retrenchment, disability and AIDS sicknesses
- That it was not possible to cover hardships that would impact on a person's ability to pay but that could be planned for – i.e. financial management.

The full report is available from the HFRP website.

## Closure

Following the presentation by Quindiem Consulting, the imbizo discussed a way forward. Odette Crofton (Social Housing Foundation) opened the discussion with the following question: "We have heard of the risks and potential impact on the SHI – To what extent is the SHI responsible, and how should it respond?" The following comments were raised in the course of the discussion.

- One participant noted the need for a representative forum of SHIs that could carry the issues and ideas forward. This body could then also operate on a macro scale in the implementation of certain measures, such as an insurance fund, so that it would benefit all SHIs jointly.
- Georgina Jaffee (Rooftops) acknowledged that participants were overwhelmed. She suggested that as a result of the day's discussion, three types of interventions were clearly necessary:
  1. **Overall perspective:** SHIs needed to act as a sector to impact nationally and create the kind of national institutions that were necessary to help the sector. This implied a need for SHIs to consider their own social responsibility, and to lobby collectively for it to be realized.
  2. **Coping/operational strategies:** SHIs needed to think about what they needed to do individually in order to cope with the crisis. This included everything from vegetable gardens through to thinking about how to get someone to a hospice.
  3. **Risk management:** SHIs need to intervene to mitigate the crisis with an attitude of survival. In this regard, SHIs need to think ahead of how they're going to prevent the orphans from getting HIV. For the second generation they have to think of how to prioritise their interventions that are going to have maximum impact from a preventative side. To this extent, the availability of anti-retrovirals (ARV) could make a significant impact in extending the productive life of tenants. SHIs should consider if they, together as a sector, could provide access to ARV, much in the same way that large corporations were now doing. But, in order for SHIs to operate from a point of information, they need to be proactive in encouraging disclosure and developing a preventative strategy.
- Ronald Fisher (GGICHC) re-emphasised the need for networking within the social housing sector. She proposed the establishment of a task team, comprising one or two people from each organization, to plan a way forward and to represent the sector in engaging with other service providers, government, etc. Participants agreed with this recommendation, and one suggested that a reportback should be scheduled in six months' time to check on progress made.
- Titus Molobi (Johannesburg Trust for the Homeless) suggested incorporating education around HIV and AIDS into a broader programme that focused on skills development.
- Silas Diamond (NUM) suggested the need to look at other treatments besides ARV which might support the immunity of PWAs as ARV were very expensive. He urged that "we need to create wealth to support health".
- Shiraz Fakir (Nurcha) urged the proposed task team to prioritise responses in terms of the short, medium, and long term. In the short term, SHIs should be capacitated to start immediately in developing their own responses. In the medium term, a comprehensive policy could be negotiated first within the proposed task team and then at tenant level. In the long term, the hardship fund could be considered.

- It was noted that the KwaZulu-Natal Department of Housing was currently re-evaluating its housing guidelines to ensure that they addressed these issues. SHIs should motivate their own provincial housing departments to do the same.
- Kecia Rust (consultant) urged participants to use the report as a basis on which to engage with one another and with the Social Housing Foundation.
- It was recommended that in future workshops, the departments of health, social services, and housing at both national and provincial levels should also invited to participate.
- Participants noted the upcoming National AIDS Day (1 December 2002) and suggested this might be a good event around which to initiate their approach.

Odette Crofton closed the imbizo and thanked all for their participation.

