



**‘Positive’ Urban Futures in Sub-Saharan  
Africa: HIV/AIDS and the Need for ABC  
(A Broader Conceptualisation)**

**Mirjam van Donk**

*'Positive' Urban Futures*

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## **'Positive' Urban Futures in Sub-Saharan Africa: HIV/AIDS and the Need for ABC (A Broader Conceptualisation)**

**Mirjam van Donk**

### **Abstract**

This paper takes issue with the narrow conceptualisation of HIV/AIDS in urban development planning as primarily (if not exclusively) a behavioural and health issue, with at best an added focus on a few apparent impacts of the epidemic. Apart from oversimplifying a complex reality, the simple message 'ABC' (abstain, be faithful, use a condom) is likely to disempower and stigmatise those who are unable to heed its call. Instead, this paper calls for a different kind of ABC, *A Broader Conceptualisation*, based on an understanding of HIV/AIDS as a complex and dynamic development issue. The paper explores factors in the urban environment that are associated with increased vulnerability to HIV infection and the likely implications of the epidemic for urban development, with specific reference to the region that is currently the epicentre of the global epidemic, sub-Saharan Africa. It concludes that 'good', equitable development possibly offers the most effective protection for individuals and urban areas against the spread of HIV and the consequences of the epidemic. At the same time, HIV/AIDS makes the realisation of equitable urban development all the more difficult – and thus more urgent.

**About the author**

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## **'Positive' Urban Futures in Sub-Saharan Africa: HIV/AIDS and the Need for ABC (A Broader Conceptualisation)**

Mirjam van Donk<sup>1</sup>

### **INTRODUCTION**

"HIV prevention is as simple as ABC (abstain, be faithful, use a condom)" is a much-heard slogan across sub-Saharan Africa. For the majority of urban residents on the subcontinent the proposed behaviour is not as simple as the catchphrase suggests. Instead, I am promoting a different kind of ABC, one that shifts the burden of responsibility from individuals and particular social groups to policy makers, planners and development organisations in the city. What is called for is *A Broader Conceptualisation*, based on an understanding of HIV/AIDS as a complex and dynamic development issue. In international development debates, it is now generally acknowledged that the HIV/AIDS epidemic poses a serious threat to the realisation of international development targets in relation to health, education, poverty eradication and gender equality, amongst others.<sup>2</sup> Moreover, at the level of rhetoric at least, there is growing recognition that HIV spread is facilitated by existing fault lines in society and that the ineffectiveness of development efforts to overcome such divisions is aggravating this situation. As yet, this understanding still needs to permeate dominant urban development planning debates and practice in sub-Saharan Africa.

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<sup>2</sup> See, for example, international development conferences hosted by the United Nations (UN), such as the United Nations General Assembly Special Session on HIV/AIDS in June 2001 and recent publications from UN organisations.



This paper seeks to contribute to a more comprehensive understanding of HIV/AIDS in urban development, with a particular focus on the region which is currently the epicentre of the global epidemic, sub-Saharan Africa. It is not my intention to suggest that HIV/AIDS is an exclusive, or even predominant, urban phenomenon on the subcontinent. Instead, I want to explore the factors in the urban environment that are associated with increased vulnerability to HIV infection, and the likely implications of the epidemic for urban development. Thus, the focus of this paper is not so much on the virus and how it affects health status and health demands, nor does it assume that individual behaviour change is the most appropriate intervention to prevent the further spread of HIV; rather, it calls for a broader perspective on the “social ecology” of HIV/AIDS (Decosas 2002) or, put differently, on HIV/AIDS as a development issue (see, amongst others, Collins and Rau 2000). This analysis will form the basis for an agenda on HIV/AIDS that locates it at the centre of urban development in sub-Saharan Africa.

It is important to mention two methodological difficulties that affect the arguments presented here. First, there is no common definition of what exactly constitutes ‘urban’ and ‘rural’ in the sub-region. Many countries use a population figure of 2,000 to distinguish between urban and rural settlements, but the figure varies widely from 100 in Uganda to 20,000 in Nigeria and Mauritius (UNCHS 2001:12).

Secondly, the reliability of both urban data and HIV/AIDS statistics is in question. Given the absence of recent and regularly updated census data for many countries in sub-Saharan Africa, global statistics on urbanisation on the subcontinent are often speculative and not particularly reliable (Satterthwaite 2005). Likewise, given the lack of universal coverage of HIV surveillance systems, HIV/AIDS data is uncertain. In fact, global HIV/AIDS data is continuously adjusted in response to better HIV surveillance systems and improved software to model the HIV/AIDS epidemic (UNAIDS 2004:209). Global HIV/AIDS data also tends to reflect an implicit urban bias, as sentinel surveillance sites are generally located in urban areas and in larger settlements in rural districts. For this reason UNAIDS prefers to use the term ‘outside major urban areas’, rather than rural areas. This distinction is again based on country distinctions, which complicates comparisons between countries.

### **THE GEOGRAPHY OF HIV/AIDS**

Clearly, the lack of consistent and reliable data on the geography of HIV/AIDS in sub-Saharan Africa, more specifically on its prevalence and manifestation in urban/rural areas over time, hinders an assessment of the epidemic's trends in urban and rural areas. It is, however, widely accepted that levels of HIV infection – like those of other infectious diseases in the past – tend to be higher in urban areas, with large urban areas showing higher HIV prevalence rates than smaller urban centres and rural areas (Dyson 2003; Harpham and Molyneux 2001).

This is not a new observation. In the early 1990s urban areas were identified as the main locus of HIV spread in sub-Saharan Africa. It was estimated that between 25-33% of the urban population in the worst affected countries were HIV-positive, compared to less than five per cent in rural areas (Panos 1992:23). In 1992 AIDS had already become the leading cause of adult mortality in some African cities (Barnett and Blaikie 1992). Towards the end of the 1990s, HIV prevalence has been observed to be four times as high in urban areas as in rural areas (Harpham and Molyneux 2001).

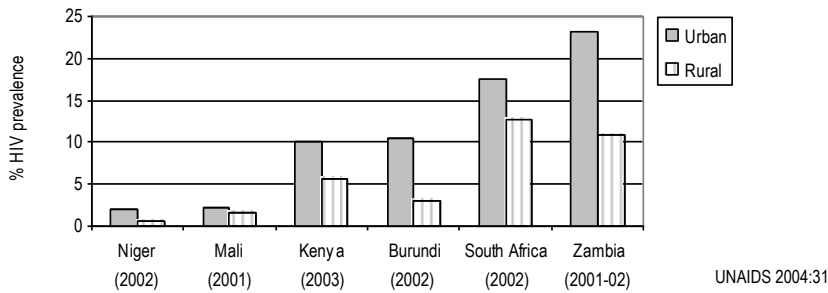
Even in rural districts with high HIV prevalence rates, HIV/AIDS has tended to be disproportionately concentrated in towns and larger settlements. In Kagera, a rural district in Tanzania, which was considered the worst affected region in the world in the mid-1980s, the main urban centre Bukoba had significantly higher HIV prevalence rates than surrounding rural areas (Lyons 2004). Similar trends have also been evident in the rural regions of Rakai, Masaka and Mwanza in Uganda. For example, a 1992 study conducted in the Mwanza region found that HIV infection rates ranged from 11.8% in town to 7.3% in roadside settlements and 2.5% in rural villages (Lyons 2004:178).

Recent UNAIDS data seems to confirm that, in many countries on the subcontinent at least, HIV/AIDS is disproportionately – but by no means exclusively – an urban phenomenon. According to UNAIDS (2002), in 21 countries in sub-Saharan Africa the HIV prevalence rate among women attending antenatal clinics in urban areas exceeds that of pregnant women in predominantly rural districts. In 12 of these countries, the urban

HIV prevalence rate among women attending antenatal clinics significantly exceeds rural infection levels, varying from around 1.5 to almost five times higher.<sup>3</sup>

Other studies confirm a higher concentration of HIV/AIDS in urban areas. For example, in Kenya the urban HIV prevalence rate in 2001 is estimated 17-18%, five percentage points higher than the rural rate (Zulu, Dodoo and Ezeh 2004). In Côte d’Ivoire, 16% of urban adults are estimated to be infected with HIV, compared to 6-14% of their rural counterparts (Oppong and Agyei-Mensah 2004). In 1997, Rwanda counted an urban HIV prevalence rate of 27%, compared to 9% in semi-rural areas and 2% in rural areas (Lyons 2004). Finally, evidence from six countries shows HIV infection levels in urban areas between 1.4 to three times higher than those in rural areas (see Figure 1). As noted earlier, even within rural districts HIV/AIDS is often concentrated in larger towns and settlements, where there are greater numbers of people and commercial activities.

Figure 1. HIV prevalence rate among 15-49 year-olds in urban and rural areas, selected sub-Saharan African countries, 2001-2003



In a number of African countries, urban and rural differentials in HIV prevalence rates have become less stark over time. For example, in countries like South Africa, Zimbabwe and Swaziland current data suggests a parallel spread of the epidemic in urban and rural

<sup>3</sup> The extent to which the HIV prevalence rate among women attending antenatal clinics in urban areas exceed those outside major urban areas are as follows: Mozambique (1.1x), Botswana (1.3x), Malawi (1.3x), Namibia (1.3x), Lesotho (1.4x), Zambia (1.4x), Ghana (1.7x), Uganda (2.3x), Congo (2.5x), Gabon (3.3x), Rwanda (3.3x) and Ethiopia (4.8x) (derived from UNAIDS 2002:192). Although UNAIDS (2004) reflects more recent global data on HIV/AIDS than UNAIDS (2002), it does not use the same distinction between ‘urban areas’ and ‘outside major urban areas’.

areas.<sup>4</sup> This trend points to the intricate linkages that exist between urban and rural areas, as evidenced in population flows, circular migration and the phenomenon of multi-locational households, amongst others. At the same time, these socio-demographic linkages may serve to obscure the full scale of HIV/AIDS in urban areas. For example, a 1996 study suggested that HIV is the primary cause of male adult mortality in Dar es Salaam, Tanzania, and that HIV and maternal mortality are the main causes of death of women in the city. However, the same study found that 11% and 19% of adult deaths recorded in two rural sites were, in fact, urban residents who had returned to the rural area after becoming sick (Kitange et al., in Harpham and Molyneux 2001:121). This suggests that the HIV prevalence rate in urban areas may be higher than local data on HIV/AIDS-related illness and death indicates.

#### **VULNERABILITY TO HIV INFECTION IN THE URBAN CONTEXT**

Evidence suggests that urban residents, and particularly urban youth, tend to show higher levels of awareness of HIV/AIDS and ways of avoiding HIV infection than rural residents (Zulu, et al. 2004).<sup>5</sup> This means that factors other than knowledge and awareness of HIV/AIDS need to be considered as possible explanatory factors for the concentration of HIV/AIDS in urban areas. A number of inter-related factors can be identified that are associated with increased vulnerability to HIV infection. It is unlikely that any of the factors presented here is alone sufficient to explain the scale and manifestation of HIV/AIDS in particular urban contexts. Case study research is essential to determine the nature, balance and interaction of factors that enhance vulnerability to HIV in specific urban localities.

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<sup>4</sup> However, even in South Africa local data shows that the HIV prevalence rate in urban and metropolitan areas often exceeds HIV infection levels in surrounding regions or provinces (see Van Donk 2002a:1).

<sup>5</sup> This observation is made in relation to Kenya. Similarly, UNAIDS (2004:74) reports that urban residents in India show more knowledge of HIV transmission. This is not to say that relevant information is equally available to all urban residents or that lack of knowledge may not be a factor in urban areas.

### **Level of urbanisation**

Based on research findings that HIV infection levels rise with increasing size of settlement in rural regions of Tanzania and Uganda<sup>6</sup>, Dyson (2003) proposes that HIV/AIDS may be positively associated with population density. Accordingly, a positive correlation may exist between HIV/AIDS and the level of urbanisation (i.e. the proportion of the national population that lives in urban areas) in sub-Saharan Africa.

Historically, cities have been associated with higher levels of infectious diseases, the emergence of new diseases and higher death rates. In 19<sup>th</sup> Century England, it was discovered that urban mortality rates, particularly as a result of tuberculosis, were significantly higher than rural mortality rates. This reality has informed the notion of the ‘urban penalty’ (see Harpham and Molyneux 2001) or, alternatively, the view of urban areas as a ‘demographic sink’ (Dyson 2003).

Many countries have effectively overcome this experience of urban disadvantage through a mix of public health interventions and socio-economic change, to the point where infant mortality rates in rural areas tend to exceed urban infant mortality rates. Yet, evidence from sub-Saharan Africa suggests that in the past three decades the locus of malnutrition and infant mortality has shifted from rural areas to small and medium-sized towns and cities, which often includes the capital city (Harpham and Molyneux 2001). Thus, the notion of urban penalty still has resonance for the subcontinent and, to the extent that urban areas are disproportionately affected by HIV/AIDS, the epidemic further underscores it.

Comparing African countries with similar socio-economic and epidemiological characteristics<sup>7</sup>, Dyson (2003) concludes that a 10 percent increase in the level of urbanisation is associated with a 3.6% increase in the adult HIV prevalence rate. Yet, as noted in the introduction, both data sets used by Dyson are flawed and to some extent

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<sup>6</sup> Dyson (2003:428) makes this observation in reference to two studies conducted in Tanzania, one by Mnyika et al (1994) and the other one by Bloom et al (2002).

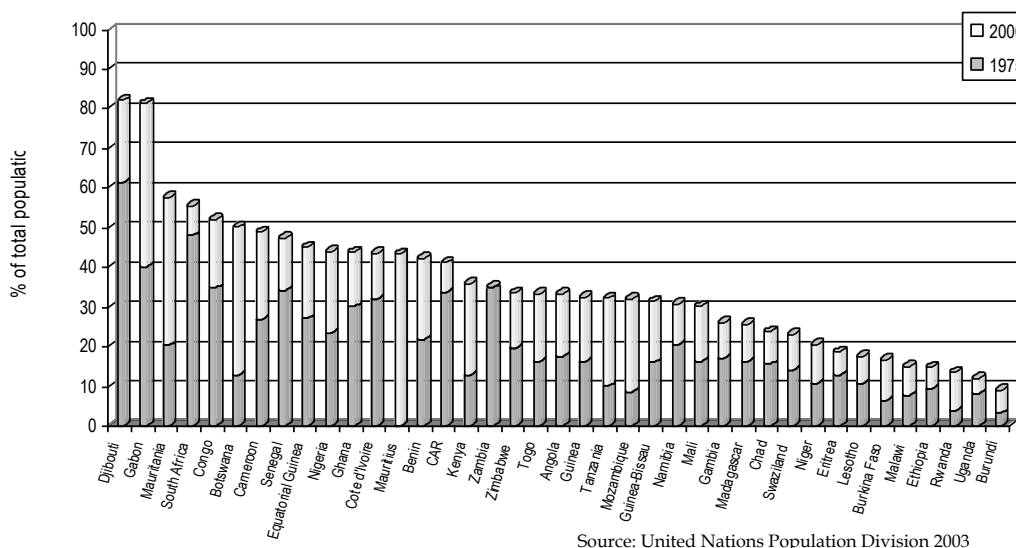
<sup>7</sup> It is important to bear in mind that different types of HIV result in different types of epidemics with different levels of severity. In sub-Saharan Africa, two types of HIV can be distinguished, HIV-1 and HIV-2. HIV-2, identified in West Africa (and also significant in Angola and Mozambique) in 1985, and is more difficult to transmit and less virulent than HIV-1, which is the dominant virus type in East and Southern Africa (Barnett and Whiteside 2002).

problematic. For example, UNAIDS has come up with revised estimates for the dataset used by Dyson (i.e. 2001 global HIV/AIDS statistics). In the case of Kenya, for example, the adult HIV prevalence rate has been revised downwards from an initial estimation of 15% to 8%, whereas in the case of Swaziland the result is an upward revision from 33.4% to 38.2% (UNAIDS 2002:190; UNAIDS 2004:191). The revisions, either upwards or downwards, for most other countries in sub-Saharan Africa have been less dramatic, but nonetheless point to the problems inherent in using quantitative data at face value. As a result, we are left with inconclusive evidence that allows us to confirm that population density is indeed a key explanatory factor for the nature and manifestation of HIV/AIDS in urban areas. Arguably, it is not so much population density per se, but the nature of interactions between urban populations and the characteristics of the urban environment that influence this interaction that may better serve to explain this reality. This will be elaborated on later in this paper.

### Rate of urbanisation

UNCHS (2001:125) defines urbanisation as 'The process – including rural to urban migration, direct immigration from foreign countries and natural population increase – by which cities capture an increasing proportion of the nation's total population.' The rate at which city populations grow and countries urbanise is indicative of the pace of social and economic change. Across sub-Saharan Africa, the period of independence and political democracy (in Southern Africa) in particular has been associated with very high volumes of rural-to-urban migration (Adepoju 1995; Satterthwaite 2005). Nowadays, urban growth in many parts of the subcontinent is largely attributed to natural growth (i.e. when urban birth rates exceed death rates), although rural-to-urban migration (and back), cross-border migration and involuntary migration (as a result of conflict or natural disasters)

Figure 2. Urban population as a proportion of the total population, sub-Saharan Africa, 1975 and 2000



Source: United Nations Population Division 2003

clearly remain significant realities across the region.

Bearing in mind the considerations noted earlier regarding the accuracy of urbanisation data, Figure 2 represents the urban population as a proportion of the total population in sub-Saharan African countries in 1975 and 2000. It shows how certain countries, like Botswana, Mozambique, Burundi, Rwanda, Tanzania, Kenya, Mauritania and Burkina Faso have experienced very rapid urbanisation during those 25 years, with up to fourfold increases. In the same period, countries like Togo, Gabon, Guinea-Bissau and Niger saw a doubling of the urban proportion of the population. In absolute numbers, when overall population growth is taken into account, the increases are even more staggering than these ratios suggest. In the case of some of these countries, like Botswana, Mozambique and Kenya, such rapid demographic change might help to explain how HIV has reached such epidemic proportions. Yet again, too many divergences exist between countries to attribute the rapid spread of HIV to urbanisation alone.

Just as the level of urbanisation in and of itself does not provide sufficient explanation for why HIV/AIDS may be concentrated in urban areas, so too does the urban growth rate *per se* fail to provide a satisfactory explanation. It is more useful to look beyond figures and to explore the extent to which urbanisation is indicative of, propelled by, or results in demographic, social and economic change that may create fertile ground for HIV to spread – and how these processes of change are managed and responded to. For example, where urban areas have been unable to provide the necessary services and employment for the growing urban population (let alone the existing population) and ensure a decent quality of life for all urban residents, urbanisation could arguably be considered a contributing factor to a context of risk and vulnerability to HIV infection in certain countries.

#### **Demographic profile of urban areas**

Rather than the level of urbanisation or the urban growth rate, the demographic profile of urban areas may be a more useful factor in explaining disproportionate HIV infection levels in urban areas. To the extent that migration contributes to urban growth, the age and gender profile of migrants needs to be considered, as well as whether the migrant travels alone or relocates with a partner and/or family. Across sub-Saharan Africa, and especially in South-Eastern Africa, it is common practice for adult men to migrate to

urban centres in search of work, leaving their partners and children in rural areas (Adepoju 1995).<sup>8</sup>

Higher HIV infection rates have been recorded among labour migrants than among those who do not migrate (Collins and Rau 2000; UNAIDS 2004:83). It is not unusual for male migrant workers to have multiple casual sexual partners in the city (see, amongst others, Campbell 2003; Kalipeni, Craddock and Ghosh 2004; Lurie, Hintzen and Lowe 2004). Yet, it has also been observed that the level of sexual activity of migrant men should not be overstated. However, if these men only buy the services of a commercial sex worker once each payday, "... they have a partner who has sexual intercourse with 15 to 30 men in the same day" (Decosas and Adrien 1997, quoted in Collins and Rau 2000:11). Even if this figure overstates the number of sexual encounters a sex worker may have, if sex is unprotected, the risk of exposure to a sexually transmitted infection is significantly increased.

Prolonged separation from one's spouse or sexual partner certainly appears to be an exacerbating factor in HIV spread – at least among men. A study on mobility, sexual behaviour and HIV infection in Yaoundé, Cameroon, found a correlation between duration of absence and HIV prevalence among men. HIV prevalence among men who had been away from home for periods longer than 31 days in the previous 12 months was 7.6%, compared to 3.4% among those who had been away for less than 31 days. HIV prevalence among men who had not been away from home in the year preceding the survey was 1.4%. No association was found between women's mobility/absence and HIV infection (Lydié et al 2004, quoted in UNAIDS 2004:33).

However, it is worth noting that the relationship between migration and HIV/AIDS is not simplistic, nor necessarily unidirectional, i.e. the result of the (often male) migrant's behaviour during periods of absence from his sexual partner (see Dladla, Hiner, Qwana and Lurie 2001; Lurie et al, quoted in UNAIDS 2004; Van Rensburg et al. 2002; Walker, Reid and Cornell 2004). It has long been assumed, for instance, that male migrant

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<sup>8</sup> In Eastern and Southern Africa, migration by women in search of economic opportunities has become more common in recent years than it was previously (see, amongst others, Lyons 2004). Adepoju (1995) notes that autonomous female migration has in fact become more widespread since the 1980s.



workers pass HIV infection on to their wives and girlfriends in rural areas. Evidence is emerging that this is not always the case. For example, in Hlabisa, a rural district in KwaZulu-Natal, South Africa, researchers found that in nearly 30% of cases in which only one partner is infected with HIV the infected person was the female partner who stayed home in the rural area (Lurie et al, quoted in UNAIDS 2004:33). Other research has shown that in nearly 40% of migrant couples, it is the woman who is first infected with HIV (quoted in Van Rensburg et al. 2002).

**Box 1. South African cities: Disproportionately male**

A recent study of the City of Johannesburg found that, notwithstanding the fact that women make up an increasing proportion of migrants into the city since 1996, women still tend to be underrepresented. In the age group of 20-39 years, men outnumber women by 100:92, compared to a national ratio of 100:108. The highest discrepancy in gender ratios is recorded in the 25-29 age group, where there are 89 women for every 100 men, compared to a national ratio of 108 women to 100 men in this age group (Van Donk 2004:14). An assessment of the age profile of Johannesburg shows that 64% of residents are between 15-49 years old (according to the national census of 2002, this age group constitutes 54% of the total national population) and 43% are between 20-39 years old (this age group constitutes 33% of the total national population). In other words, the age and gender profile of the city is dissimilar to the national profile of the South African population. Other major cities in South Africa reflect a demographic profile similar to the one of Johannesburg (SACN 2004:179).

Another important aspect is the youthful nature of African city populations. Six out of ten Africans are under 24 years of age. Although specific urban data could not be found, it seems reasonable to assume that the urban population has a similar age profile, if not an even more youthful profile (see Box 1). Although it should not be assumed that young people are generally sexual active or promiscuous, studies have shown that adolescents who start sexual activity at an early age (and before the age of 15 is not uncommon) are likely to have more sexual partners over time, including partners who have been at risk to exposure to HIV infection, and are not likely to use condoms (UNAIDS 2004). A South African study revealed that urban youth have significantly more sexual experience than their rural peers; young people in informal urban settlements in the age groups 12-14

years and 15-24 years have the highest level of sexual experience in comparison to their contemporaries in other localities (HSRC 2002:70). With the majority (between 50-60%) of new HIV infections occurring in the 15-24 years age group (mainly among young women) and over 60% of all young people living with HIV/AIDS residing in sub-Saharan Africa (UNAIDS 2004:93), the age profile of African cities seems to be an important factor that warrants further investigation.

One aspect that has as yet not been given much attention is the extent to which levels of HIV infection in urban areas may be raised by the movement from rural areas of infected people from rural areas, who hope to access better care and services, or to escape stigma in their home communities. The fact that even basic medicines and health care are lacking in many rural areas suggests that this could be a factor – although by the same token the lack of health facilities, especially testing centres, may also mean that many rural residents remain unaware of their HIV status. Clearly, more research is needed to investigate this. Of course, this is not to suggest that adequate health facilities are readily accessible in urban areas on the subcontinent.

#### **Social mores and interaction**

With urban areas being “key areas of interaction between populations” (UMP 2002:9), another factor to explore is whether people in urban areas behave and interact in ways that enhance the likelihood of HIV spread. There has been a tendency to blame urban sexuality, often associated with immorality, for the spread of HIV/AIDS in sub-Saharan Africa (Oppong and Kalipeni 2004:53). This is hardly surprising, as for most of the past 20 years the global paradigm on HIV/AIDS has been dominated by a concern with individual sexual behaviour (see, amongst others, Craddock 2004; Collins and Rau 2000; Van Donk 2005).<sup>9</sup>

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<sup>9</sup> Given the disproportionate HIV/AIDS burden in sub-Saharan Africa, focusing exclusively on sexual behaviour as a mode of HIV transmission – without taking account of the socio-economic contexts within which sexual practices occur and the amount of power and discretion individuals have to act on knowledge related to HIV prevention – also holds the danger of stereotyping Africans as sexually promiscuous as opposed to ‘civilised’ nations (for a critique of this view, see Oppong and Kalipeni 2004; Treichler 1999).

Without attaching moral values to sexual networking patterns among urban residents, some observations can be made. For one, urban residents tend to marry later, which may influence sexual relations (Baylies 2000; Dyson 2003). Perhaps the fact that usually a higher proportion of the urban population reports non-regular sexual relationships compared to the rural population confirms this point (Dyson 2003; HSRC 2002) – although this does not preclude the likelihood that such relationships take place within the context of marriage, too.<sup>10</sup> It has further been suggested that urbanisation is associated with a loss of social control and a reduced influence of moral systems, including diminished elder authority, on individual behaviour (Collins and Rau 2000; UN-Habitat 2004).

Of course, sexual interaction is not necessarily consensual. In 2001, WHO reported that in some countries up to 33% of girls reported that their first sexual experience was coerced (quoted in UNAIDS 2004:40). According to a United Nations International Crime Victim Survey, women in Africa experienced higher levels of rape and attempted rape compared to women in other major regions (quoted in UN-Habitat 2004:146). Although comparisons between urban and rural areas are scarce, a government survey conducted in South Africa found that women in urban areas were more at risk of sexual violence: rape and sexual abuse affected five percent of urban women and 3.6% of rural women (quoted in Van Rensburg et al. 2002:9). It is well-known that sexual violence remains seriously under-reported.

Clearly, an understanding of the socio-cultural and economic settings that influence behaviour, agency and social interaction – and specifically sexuality and sexual practices – is required (see, amongst others, Campbell 2003). In particular, attention needs to be given to specific urban conditions that encourage sexual behaviour that facilitates (or possibly hinders) the spread of the epidemic and the extent to which urban populations

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<sup>10</sup> UNAIDS (2004) refers to evidence from some African countries where married young women (15-19 years old) have higher HIV infection levels compared to their non-married sexually active peers. Similar observations have been made with respect to Uganda (Carpenter et al 1997, quoted in Baylies 2000:11) and Ethiopia (presentation by Richard Mabala at the Ford Foundation seminar on urbanisation, environment and development in sub-Saharan Africa, 24-27 February 2005, Cape Town). This leads UNAIDS (2004:40) to conclude: "Marriage and other long-term, monogamous relationships do not protect women from HIV."

have access to (and make use of) appropriate HIV prevention methodologies. Both factors are discussed below.

### **Health status**

Health status relates to vulnerability to HIV infection in a number of ways. First, if one's health status is low, the virus has a better chance of taking root. (Also, poor health and nutrition are likely to accelerate the onset of HIV/AIDS-related illnesses and death.) Health status tends to be highly dependent on income, which has become less secure and has been in decline for a high proportion of urban populations as a result of structural changes associated with the global economy (UN-Habitat 2004). Further evidence for the connection between poverty and nutritional status is presented by Haddad, Ruel and Garrett (1999), who found that in most developing countries surveyed the poor and undernourished in urban areas had increased, both in terms of absolute numbers and proportionally, relative to those in rural areas.

Secondly, someone who is infected with a sexually transmitted infection (STI) is more susceptible to HIV infection. The link between STIs and HIV was first observed in a study conducted in Mwanza, Tanzania, in the early 1990s, which demonstrated that improved STI treatment services resulted in a significant reduction in HIV incidence (Barnett and Whiteside 2002). A study in South Africa found evidence of higher levels of self-reported STIs in urban areas than in rural areas, with a significantly higher prevalence of STIs in informal settlements (HSRC 2002:56). The likelihood of HIV spread in urban areas, and especially in informal neighbourhoods, is thereby enhanced. STI prevalence is, of course, indicative of unprotected sex in non-monogamous relationships. A UNAIDS (1999) study comparing differences in HIV spread between four urban areas in Africa (Kisumu, Kenya; Ndola, Zambia; Cotonou, Benin; and, Yaoundé, Cameroon) found no obvious differences in sexual behaviour that could account for the higher levels of HIV in East African cities. What was remarkable, though, was that the two towns with the highest HIV prevalence rates (Kisumu and Ndola) also had significantly higher levels of STI infection.

Finally, health status is directly influenced by accessibility of appropriate health care services (Walker et al. 2004) and, in the case of HIV prevention, of reproductive health services and HIV prevention methodologies (e.g. condoms, STI treatment, prevention of

mother-to-child transmission). To the extent that such services are inaccessible, inappropriate or unaffordable for (specific groups of) urban residents, their vulnerability to HIV infection is enhanced. For example, labour migrants often do not have adequate access to STI treatment (Collins and Rau 2000:11).

### **Poor quality urban environments**

Health status is related to the quality of urban environments. Poor living conditions and high levels of informality characterise the lives of most city residents in sub-Saharan Africa. Between 1990 and 2001, the subcontinent has seen a significantly higher growth in the number and proportion of slum dwellers relative to overall population growth (UN-Habitat 2003:116). UN-Habitat (2003:25) estimates that seven out of ten urban residents in sub-Saharan Africa live in slums.<sup>11</sup> Data shows that “... slum residents start sexual intercourse at earlier ages, have more sexual partners, and are less likely than other city residents to know of or adopt preventive measures against HIV infection” (UN-Habitat 2004:120). Confirming these points, a study of the relationship between urban living conditions, sexual behaviour and reproductive health outcomes in four slum areas in Nairobi found that economic deprivation and precarious living conditions contribute to enhanced vulnerability to HIV infection for slum dwellers (Zulu et al. 2004). Similarly, in South Africa youth in urban informal areas are on average sexually active at a younger age than their contemporaries living in other localities (HSRC 2002:70). They were also more likely to have had more than one sexual partner in the year preceding the community-based survey. However, the same study observed a higher rate of condom use among men and women in urban informal areas at last sexual encounter compared to those in urban formal settlements and rural areas (Ibid:75).

The reportedly higher rate of condom use (at last sexual encounter, at least, which does not imply consistent condom use) notwithstanding, HIV prevalence in urban informal settlements in South Africa is estimated to be almost double that of urban formal settlements, namely 21.3% and 12.1% respectively. In rural settings, HIV infection levels are even lower (Ibid:47). Evidence from Johannesburg confirms that those living in

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<sup>11</sup> There is no common definition of the term “slum”. The United Nations defines a slum as an area that combines the following characteristics: inadequate access to safe water; inadequate access to sanitation and other infrastructure; poor structural quality of housing; overcrowding; insecure residential status (UN-Habitat 2003:12).

private housing have lower levels of HIV infection than those living in informal settlements (Thomas 2003).

Another aspect of the urban environment that may facilitate the spread of HIV relates to the existence of single-sex (often male) compounds that house migrant labourers, soldiers or members of the police, for example. Overcrowding and lack of privacy mean few opportunities for intimate relationships (see Campbell 2003; Collins and Rau 2000). Within such contexts, masculine identities tend to be closely intertwined with a strong sex drive and sexual conquests, with little room for safe sex practices (Campbell 2003; Walker et al. 2004).

Migrant labourers in Kenya also suggested that lack of recreational facilities and electricity (to watch television or listen to music) leads to boredom, which increases the likelihood of casual and unprotected sex (Rugalema et al. 1999, quoted in Collins and Rau 2000:11). Similar observations are made regarding the lack of television (which is in large part related to the lack of affordable and reliable electrical connections) to keep township youth entertained in South Africa (Walker et al. 2004).

#### **Urban economy / urban poverty and inequality**

A number of trends and characteristics of the urban economy serve to enhance HIV spread.

For one, urban economies are often linked to rural and other urban economies, including cross border economies, through transportation networks. Such networks not only facilitate flows of goods and people, but also of infectious diseases like HIV/AIDS. Cities and towns along main transportation routes tend to show higher HIV infection levels than surrounding areas (CIIR 1999; Jackson 2002).

Secondly, urban economies are particularly vulnerable to changes in the global and macro-economic environment. In recent years, industries dependent on highly skilled workers have largely benefited from processes of globalisation, whereas labour-intensive industries dependent on low-skilled and semi-skilled labour have declined. This has resulted in growing levels of urban unemployment (among both men and women, who tend to be employed in different economic sectors that are affected by global economic

restructuring and trade liberalisation), informalisation of the economy, lack of secure income, a growing proportion of the poor in urban areas, and increasing income inequalities, all of which is clearly evident in cities and towns in sub-Saharan Africa. Here, the proportion of the urban poor is growing faster than the total urban population, a phenomenon described as the urbanisation of poverty (UN-Habitat 2004:104). Closely associated with this is the feminisation of urban poverty, which is further discussed below.

Poverty, unemployment, lack of secure income and income inequality have been identified as core determinants of vulnerability to HIV infection (Collins and Rau 2000; Van Donk 2004b), particularly when these factors are combined with inadequate access to appropriate services, inability to afford the means for HIV prevention or access to health care, power imbalances, loss of self esteem (e.g. where men are unable to fulfil their gender role as breadwinners), frustration and disillusionment, and a preoccupation with immediate survival needs. Where daily survival is continuously negotiated, it is unrealistic to expect people to take seriously the as-yet invisible threat of ill health and death at some time in the future (see, amongst others, Campbell 2003; Collins and Rau 2000; Marais 2000; Zulu et al. 2004). In such a context of disempowerment, it is not unlikely that physical and sexual power may be seen as the only way to assert oneself and one's masculinity (Campbell 2003) – although rape and gender-based violence are by no means restricted to lower socio-economic groups.

In such circumstances, sexual bargaining or sexual networking may become an essential, yet hazardous, livelihood strategy. The commercial sex industry often makes a vital contribution to the urban economy and it is well-known that the HIV prevalence rate among commercial sex workers in a particular town or city significantly exceeds that of the city population. For example, recent UNAIDS data for seven African countries shows that commercial sex workers in the capital cities have HIV infection levels that are between four (Kenya) to 32 (Benin) times higher than the average national adult HIV prevalence rate (UNAIDS 2004:194).<sup>12</sup> Commercial sex workers are generally not in a

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<sup>12</sup> The sub-Saharan African countries for which data is available are: Angola, Benin, Guinea, Kenya, Madagascar, Mali and Senegal. Only in Madagascar is the reported HIV prevalence rate among commercial sex workers in the capital city below the national adult HIV prevalence rate, namely 0.2% and 1.7% respectively (UNAIDS 2004:191, 194).

position to negotiate safe sex, even though they may be very aware of the risk of HIV infection as a result of targeted awareness campaigns (see CIIR 1999:17; UNAIDS 2002:98-101).

Sexual networking is often a last resort survival strategy for poor women and girls, often involving 'sugar daddies' and the exchange of sex for money, food, clothes, gifts or protection (Baylies and Bujra 2000; Collins and Rau 2000; Zulu et al. 2004). In these situations of unequal power relations, if not powerlessness, it is highly unlikely that safe sex can be demanded. A study in Nairobi's slum areas found that men exploit women's desperation by giving as little as possible in exchange for sexual gratification (Zulu et al. 2004). As Mabala (2005) notes, sexual networking is not necessarily based on a decision by the women or girls involved. Referring particularly to young girls in two low income areas in Addis Ababa, Ethiopia, he notes that it is not unusual for girls to be sent out to 'find the evening meal' by their parents or caregivers (Mabala 2005:10).

#### **Gender relations / the status of women and girls**

Gender inequality is widely prevalent in sub-Saharan Africa. One of its manifestations is unequal access to and ownership of assets, including productive assets, such as housing and land. Lack of (independent) access to housing allows women in urban areas less leverage over their partners' actions and (sexual) behaviour. It also compels women to stay in abusive relationships (UN-Habitat 2004:152). The South African study highlighted earlier suggests that violence against women, and specifically sexual violence, is more prevalent in urban areas than in rural areas, although this is clearly an under-investigated and under-reported issue.

Evidence suggests that women have become increasingly exposed to poverty during the 1990s. The feminisation of urban poverty manifests itself in a disproportionate number of women in informal employment<sup>13</sup> (mainly in the less profitable areas of the informal sector) and in casual jobs, and a growing number of female-headed households among those without any source of income and/or without access to a public safety net (e.g. healthcare and child care) (Kabeer 2003; UN-Habitat 2004). This situation leaves women

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<sup>13</sup> The share of the female labour force in the informal sector in sub-Saharan Africa rose from 10% in 1970 to 18% in 1990 (Kabeer 2003:133).



and girls vulnerable to exploitation and abuse, especially where their subordinate status is entrenched in law. As noted earlier, it may also compel them to exchange sex for money, goods, services or protection.

Women's subordinate socio-economic and legal status is mirrored in sexual relations, where women are often not in a position to insist on faithfulness or protected sex by their partners, including husbands. Even where women's equality has been established in legislation (as in South Africa, for example), entrenched power imbalances in the 'private' domain tend to characterise the lives of most women. Coerced sex, including marital rape, virgin rape (informed by the myth that sexual intercourse with a virgin is a cure for HIV/AIDS) and other forms of forced sex (often not recognised as rape by women and girls), is a reality experienced by many women and girls in urban areas. In South Africa, for example, four out of ten girls between 12-17 years old have been forced to have sex and 55% of girls indicate that they sometimes engage in sex because their boyfriend insists (Vetten 2001:4). Thus, an ironic situation may exist whereby urban women may experience greater opportunities and freedom compared to rural women, but in an environment that may be more dangerous to their physical and emotional well-being.

In addition to physiological factors<sup>14</sup>, it is these realities – and the underpinning power imbalances – that have contributed to higher HIV infection levels among urban women, particularly young women and girls between 15-24 years old. The difference in HIV infection levels between men and women tends to be higher in urban areas than in rural areas in sub-Saharan Africa. In rural areas, for every 10 men infected with HIV there are 12 women with HIV, whereas in urban areas the ratio is 10:14 (UNAIDS 2004:31). The gender differentials in levels of HIV infection are most pronounced among those aged 15-24 years, with young women showing significantly higher levels of HIV infection compared to their male peers, ranging from 10:20 in South Africa to 10:45 in Kenya and

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<sup>14</sup> UNAIDS has estimated that, all else being equal, the probability of male to female transmission is two to four times that of female to male transmission (quoted in Baylies 2000:4). There are a number of reasons for this: higher concentrations of HIV in semen than in vaginal fluid; a greater exposed female genital surface area; mucous membranes of the vagina more permeable than those of the penis; a greater likelihood of tearing of female genital tissue, particularly during 'dry sex'; and, in the case of young women and girls, genital tracts that may not be fully developed (Baylies 2000; Vetten 2001).

Mali (Ibid). Marriage does not necessarily provide protection from HIV infection; in fact, evidence from a number of African countries suggests that marriage increases women's vulnerability to HIV infection (see footnote 11 and Baylies 2000; Grundfest Schoepf 2004; UNAIDS 2004:40). In most instances, women report being faithful to their husbands and become infected '... not through 'improper' behaviour, but in consequence of complying with norms of fidelity, if their husband has unprotected sex outside of marriage' (Baylies 2000:11).

#### **DIFFERENTIAL LEVELS OF VULNERABILITY**

Based on the preceding discussion, it is obvious that not all urban residents are equally vulnerable to HIV infection, or to its consequences. Thus, intra-urban differentials need to be taken into account. A number of (overlapping) social groups can be identified that, possibly for different reasons and in different urban settings, have disproportionate levels of vulnerability to HIV infection. These include: women and girls, especially those in their mid teens to late twenties (and their babies/infants, through mother-to-child transmission); migrants and their sexual partners in rural and urban areas; slum residents; unemployed youth, particularly those who have dropped out of school, who are low-skilled or semi-skilled; men living in single-sex or predominantly male compounds (e.g. soldiers, migrant workers – even prisoners); and, commercial sex workers. Contextual differences aside, vulnerability to HIV infection is likely to be most severe where the various factors described above overlap, e.g. among girls and young women in slums, with low levels of education and no stable source of income, yet with the responsibility to provide for the wellbeing of others.

In addition, children from poor households, especially HIV affected households, orphans (especially those orphaned by AIDS) and street children may be particularly vulnerable to HIV infection. Children from HIV-affected households may be sent away from home as a 'cost-cutting' measure or they may need to start working to contribute to household income (see UNAIDS 2004:63). Similarly, orphans may be compelled to contribute financially to their new homes – unless no one has been willing or able to look after them, in which case there is a high probability that they end up on the streets. Sex work and occasional sex in exchange for money or something to eat may be the only source of income or food for these children. Also, without the protective environment of their

homes, these children face increased risk of violence and abuse, including sexual exploitation and abuse.

Refugees and internally displaced persons are another group faced with increased vulnerability to HIV infection. Although refugee camps are commonly located in rural areas, urban areas may be affected in two ways. On the one hand, these people may be urban dwellers fleeing natural disasters or armed conflict. On the other hand, refugee camps may be located on the outskirts of towns and cities. Even in predominantly rural areas, refugee camps may take on an urban character, not merely by virtue of population density, but also in the sense that new economies may emerge, in which the hospitality industry and commercial sex work play a central role. Yet, condoms are most often lacking in these situations. To illustrate this point, a representative of the United Nations reported that many refugees from Rwanda in Goma first requested condoms, not food or medicine (Lyons 2004:189). In refugee camps, HIV prevention tools are likely to be scarce, STI treatment may not be available, and women and girls (and even boys) are highly vulnerable to sexual exploitation and violence (often inside as well as outside the camps) (Holden 2003).<sup>15</sup> As a result, both populations in refugee camps and surrounding areas are vulnerable to the spread of HIV.

#### **COPING WITH THE CONSEQUENCES OF HIV INFECTION: ERODED RESILIENCE**

HIV/AIDS is clearly associated with socio-economic vulnerability, marginalisation and inequality, although it obviously does not exclusively affect marginalised groups. Marginalised socio-economic groups also tend to have weak capability to cope with the consequences of HIV/AIDS-related illnesses and death, often for reasons similar to those that enhance their vulnerability to HIV infection. Whereas those with means can afford to pay for life-enhancing and life-prolonging treatment in the private health care sector, or are likely to have access to some form of income even if they are no longer capable of engaging in productive work, for the majority of urban dwellers in sub-Saharan Africa such support is beyond their means, and out of their reach.

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<sup>15</sup> However, recent evidence suggests that HIV infection levels among refugees do not necessarily exceed the HIV prevalence rate of the surrounding host community. Among the reasons suggested for this is the fact that refugees are often located in remote rural areas with limited freedom of movement and, thus, limited interaction with the local population (UNAIDS 2004:179).

In the absence of universal access to treatment or a cure, HIV/AIDS follows two pathways: morbidity (ill health) and mortality (death). The immediate consequences of HIV/AIDS-related morbidity have been well-documented (see, amongst others, Barnett and Whiteside 2002; UNAIDS 2002 and 2004; UMP 2002). These include: the need for treatment and appropriate care; higher medical costs (whether treatment is sought in the formal or informal health sector); increased pressure on other family members (commonly women and girls) to look after the sick; a loss of productive time and possibly income or food security; and stigma, exclusion and discrimination if HIV status is known or suspected. The direct consequences of HIV/AIDS-related mortality include: widowhood and orphanhood; funeral costs; loss of income or livelihood (if the deceased was an income provider); loss of entitlements and assets, such as a house or land, and other forms of security (particularly if the deceased was considered the male head of household); a breakdown of household structures and pressure on households to accommodate those affected by an AIDS-related death; new groups of marginalised and poor people (e.g. widows, AIDS orphans, elderly care givers); and, again, stigma, exclusion and discrimination if an AIDS death is known or suspected. The dominant response to HIV/AIDS tends to focus on some or a combination of these direct consequences of HIV/AIDS (see van Donk 2004b).

In seeking to deal with these immediate consequences of HIV/AIDS-related ill health and death, urban residents and households tend to adopt a range of coping strategies (see Tables 1 and 2), which include: diverting income from other needs (e.g. food, clothing, transport, rent, basic services) towards medical and funeral costs of the HIV-infected relative(s); selling assets and borrowing; income substitution, which may include sexual networking; and return to rural areas for care or support or to avoid stigma.

Whereas these coping strategies may be the only viable or rational options for individuals and households in distress, in the medium and long term these strategies have a number of negative implications for the human rights, development and overall well being of individuals (especially women and children) and households. Tables 1 and 2 highlight some of these implications, which can be considered indirect consequences of the HIV/AIDS epidemic.

Depending on the stage and intensity of the epidemic, the direct and indirect consequences of HIV/AIDS are likely to go beyond the individual/household level (where such consequences tend to remain invisible to the eye of policy makers and planners) and to affect communities, the city, sectors and institutions. In countries or urban areas highly affected by HIV/AIDS and where universal access to antiretroviral treatment is not available, the cumulative impact of HIV/AIDS and household-level responses are likely to include:

- An increase in the burden of disease and death, especially among young women and men in their late teens and twenties and among babies/infants (already evident);
- A changing demographic profile, particularly in terms of age and gender (see, amongst others, Barnett and Whiteside 2002);
- More and deeper levels of poverty and inequality, including a lack of food security<sup>16</sup> (see UNDP 2002);
- Entrenched gender relations and gender inequality, largely related to the disproportionate care burden placed on women (so-called ‘care economy’, see UNAIDS 2004:130);
- The collapse of family/household structures and a growing number of orphans (already evident – see, amongst others, Ghosh and Kalipeni 2004; Jackson 2002; UNAIDS 2004);
- An increase in homelessness and in the number street children (see, amongst others, Ghosh and Kalipeni 2004);
- Loss of parents, (future) leaders and productive members of community;
- Reduced productivity, with negative implications for the urban and national economy (see Barnett and Whiteside 2002; Jackson 2002);
- Possibly outmigration, or at least slower rate of urbanisation (due to HIV/AIDS-related increase in the number of deaths and decline in natural growth) (Dyson 2003);
- A reduced prospect of human development; and, as a result of all of these,
- Enhanced vulnerability to HIV infection.

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<sup>16</sup> Poverty increases as a result of a reduced ability to earn an income, combined with higher treatment and care costs and a loss of assets. In Côte d’Ivoire, urban households affected by HIV/AIDS have seen their health care expenditure rise by 400% whilst their incomes have dropped by 52-67%. As a result, these households have had to cut their food consumption by up to 41% (UNAIDS 2001).

The multiple impacts of the HIV/AIDS epidemic serve to further undermine community resilience and the capacity to cope with shocks and stresses, and to erode the urban fabric. As a result, there is greater demand for external support and services, but also for qualitatively different services and support for HIV/AIDS-affected individuals, households and communities. For example, the extra demand for health care comes predominantly from an age group that is ordinarily not affected by a high disease burden and, in the case of young girls, may remain largely invisible to health policy makers and practitioners as a result of a systemic 'gender blind spot' (see also Mabala 2005). Not only are there more people needing health care, their needs are also for more complex, more varied and more demanding treatment regimes and care. Furthermore, as more households fall into deeper poverty as a result of HIV/AIDS, the need for secure tenure, basic services, food security and so on increases. Yet, many HIV/AIDS affected households no longer have an adult who – in policy terms – can be considered a breadwinner, caregiver, beneficiary or account holder, which makes the provision of equitable urban services much more complex.

These demands put significant pressure on city level organisations, including the local state and organisations of the urban poor, to provide the required safety nets – over and above required support for existing needs and entitlements of urban residents that are unrelated to HIV/AIDS. Yet, in urban areas with relatively high HIV infection levels, city level organisations are likely to be weakened by the HIV/AIDS epidemic, due to higher levels of absenteeism among HIV-infected and affected staff and a high attrition rate as a result of HIV/AIDS-related death or resignation/dismissal (following reduced capability to execute tasks). Attrition is associated not only with a loss of human resources, but also with a loss of skills, capacity and organisational memory, which is particularly difficult to replace. At the same time, organisations are faced with increasing costs as a result of HIV/AIDS, such as higher medical costs, replacement costs, retrenchment packages, death benefits, and so on (UNDP 2002). Whilst both organisational costs and the external demand for support and services are likely to increase, the local revenue base is likely to be reduced, as HIV/AIDS-affected households are unable to pay local taxes, levies and service charges and as the pool of those considered 'account holders' (according to current criteria) is diminishing. Collectively, these impacts undermine the capability of city level organisations to execute their mandate. This, in turn, puts greater pressure on urban communities and households to step in and mobilise the necessary support, usually

on a voluntary basis. Yet, as noted earlier, HIV/AIDS can undermine traditional support networks and community resilience, not least because of the associated stigma and prejudice.

This is not to say that communities are passive in response to the HIV/AIDS epidemic. Worldwide, there are innumerable examples of communities mobilising to provide care, look after orphans or campaign for the realisation of specific rights to reduce vulnerability to HIV infection, amongst others. Yet, there are also countless instances of communities seeking to cope with the HIV/AIDS epidemic in ways that are exclusive and excluding; where ill health, death and devastation stemming from HIV/AIDS give rise to systems of meaning that apportion blame and sanction rejection of those affected by the epidemic (CIIR 1999; Walker et al. 2004). The result is greater social polarisation, following both existing and new social fault lines.

Furthermore, in countries or regions where HIV/AIDS is disproportionately concentrated in urban areas, rural communities are not impervious to the impacts. For example, during a visit to Siaya, a rural district in Kenya, Jeffrey Sachs and his colleagues from the UN Millennium Project heard that rural households no longer received remittances from migrants – instead, “...the only things coming back from the cities were coffins and orphans, not remittances” (Sachs 2005:33).

It is this association of HIV/AIDS with urban residents, reinforced by the fact that rural communities tend to experience increased numbers of HIV infection after visits by urban migrants or ‘outsiders’ who come to take up seasonal work or for a holiday, that in some instances has led to apprehension, if not stigma, of urban residents as vectors of disease and death in rural communities (Zulu et al. 2004).

#### **TOWARDS A COMPREHENSIVE DEVELOPMENTAL RESPONSE TO HIV/AIDS IN URBAN AREAS**

Recognising the socio-cultural, political and economic context in which the HIV/AIDS epidemic seems to flourish is essential for an effective response to HIV/AIDS in urban areas. This involves a degree of comprehensiveness, both at conceptual level and at the level of strategy and action, that is at present largely lacking in urban governance, planning and development in sub-Saharan Africa. Figure 3 summarises a range of

interventions that need to be considered as part of such a comprehensive response. The particular emphasis or appropriate mix of interventions clearly has to be determined with reference to trends and dynamics in specific localities.

Although Figure 3 broadly reflects similar areas of intervention for the reduction of vulnerability to HIV infection and for responding to its consequences in urban areas, the nature of interventions is likely to differ, depending on whether the intention is to prevent HIV spread or to ensure that the negative impacts of HIV/AIDS (on individuals, households, communities, organisations or institutions) are minimised. To give an obvious example within the area of biomedicine and health, equitable access to reproductive health services and technologies, STI treatment and a vaccine have particular relevance for the prevention of HIV infection, whereas access to anti-retroviral treatment is about ensuring that those infected with HIV can live longer, healthy, productive and dignified lives. Similarly, access to sustainable employment and a fair distribution of income can reduce vulnerability to HIV infection, resulting from power imbalances and mere desperation to survive and provide for loved ones; continued access to education, secure employment and a decent income are also essential impact mitigation strategies, ensuring that affected households and individuals do not fall way below the edge of subsistence, with their prospects for human development seriously compromised and their human rights unrealised.

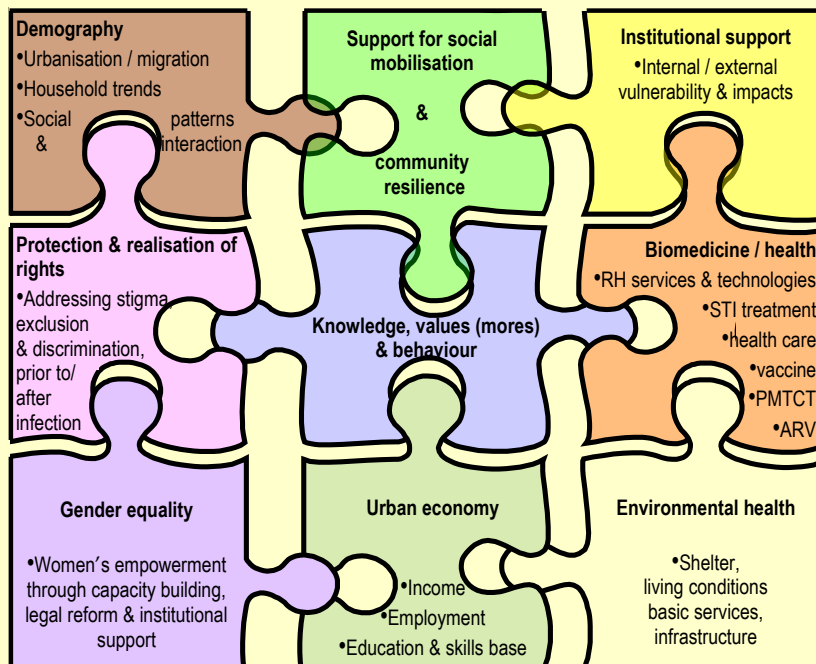
The promotion of enhanced awareness and behaviour change is a familiar area of intervention aimed at HIV prevention. It is located in the centre of the graph, because it will only be effective at scale if it is supported by and anchored in interventions aimed at addressing relevant socio-cultural, political, economic and technological factors of vulnerability to HIV infection. A better understanding of HIV/AIDS and attention to fears, prejudices and negative attitudes towards people infected and affected by the epidemic are also essential to overcome stigma and social exclusion associated with HIV/AIDS (i.e. key negative consequences of the epidemic).



With respect to each identified area in Figure 3, it is possible to articulate interventions aimed at HIV prevention and the reduction of vulnerability on the one hand, and preempting or minimising the negative consequences of HIV infection on individuals, households, communities, organisations or institutions on the other hand. Arguably, in the case of demography the issue is not so much about intervention (lest we come to the conclusion that urban migration should be curbed at all cost, for example)<sup>17</sup>, but more about the need for an improved understanding of how particular demographic trends enhance the spread of HIV and, vice versa, how HIV/AIDS influences demographic trends. Whereas significant consideration has been given to the impacts of HIV/AIDS on mortality, life expectancy and population structure, broader dynamics of the epidemic’s implications for urbanisation or household trends have not received the same amount of attention. With an increasing awareness of the emergence of child-headed households and ‘missing-generation-households’ (consisting of grandparents and grandchildren only), this seems to be slowly changing.

Perhaps the best way of summarising Figure 3, and the analysis put forward in this paper, is that ‘good’, equitable development possibly offers the most effective protection for individuals and urban areas against the spread of HIV and the consequences of the epidemic. Given the evident inability of relevant actors to realise equitable urban

**Figure 3. Mutually enforcing elements of a comprehensive response to HIV vulnerability and HIV/AIDS in urban areas**



development, even without HIV/AIDS, the challenges are clearly significant. At the same time, HIV/AIDS undoubtedly makes the realisation of equitable urban development even more urgent (Van Donk 2002b).

#### **CONCLUDING COMMENTS**

Even though the international community has known of HIV/AIDS for some 20 years now, there is a surprising lack of awareness of and response to HIV/AIDS, particularly in the context of urban development. On the one hand, this is indicative of the persistence of a narrow conceptualisation of HIV/AIDS, which considers it in terms of virus, behaviour and, more recently, stigma and visible impacts (especially orphans). On the other hand, and perhaps ironically, there are many aspects and ramifications of the epidemic that we simply do not know about; the specific nature of vulnerability in urban contexts and among particular groups of urban residents, how HIV/AIDS manifests itself in particular urban localities and the implications of HIV/AIDS for urban development have not been sufficiently explored and documented. This points to the need for more research and better knowledge sharing, especially with respect to the nature and manifestation of HIV/AIDS in particular African towns, cities and urban neighbourhoods. It goes without saying that such investigations would need to start with ABC – a broader conceptualisation of HIV/AIDS, as promoted in this paper.

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**Table 1. Impacts of HIV/AIDS-related morbidity at individual, household, community / city and sector / institutional level in urban areas**

	<b>Symptomatic – HIV/AIDS-related illnesses</b>	<b>Potential coping strategies</b>	<b>Possible implications of coping strategies</b>
<b>Individual</b>	<ul style="list-style-type: none"> <li>• Repeated bouts of ill health + need for treatment/care</li> <li>• Higher medical costs</li> <li>• Loss of income + productive time (e.g. to produce food)</li> <li>• Possible stigma, exclusion + discrimination if HIV status is known or suspected</li> </ul>	<ul style="list-style-type: none"> <li>• Diversion of income from other needs (e.g. food, clothing, transport, rent, basic services) to medical costs</li> <li>• Selling assets + borrowing</li> <li>• Attempt to hide HIV status because of associated stigma, or: disclosing HIV status, possibly joining PLWHA group</li> <li>• Return to rural area for care</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of adequate nutrition, clothing, etc.</li> <li>• Possibility of eviction</li> <li>• Eroded asset base, debt, deeper poverty</li> <li>• Social isolation / loneliness or, alternatively, inclusion in support network</li> <li>• Pressure on rural comm. (women) to provide terminal care</li> </ul>

<p><b>Household</b></p> <ul style="list-style-type: none"> <li>• Increased pressure to look after the sick (with physical, emotional, time implications)</li> <li>• Loss of household income and/or food security due to ill health</li> <li>• Possible stigma, exclusion + discrimination if HIV status is known or suspected</li> </ul>	<ul style="list-style-type: none"> <li>• Diversion of tasks to provide care (esp. women, children, elderly)</li> <li>• Diversion of household income and/or assets from needs of other household members (food, clothing, education, transport, etc.)</li> <li>• Selling assets + borrowing</li> <li>• Children taken out of school (to help with household tasks, care for the sick, earn income or affordability reasons)</li> <li>• Income substitution, possibly through sexual networking</li> <li>• Attempt to hide HIV status because of associated stigma</li> </ul>	<ul style="list-style-type: none"> <li>• Loss of productive time or certain needs unmet/delayed</li> <li>• Loss of nutrition (especially women and girls) + forfeited development opportunities (education)</li> <li>• Eroded asset base, debt, enhanced poverty</li> <li>• Loss of educational opportunities → implications for human devt (esp. girls) + ability to escape poverty</li> <li>• Risk of exploitation + abuse</li> <li>• Risk of STD/HIV infection</li> <li>• Social isolation</li> </ul>
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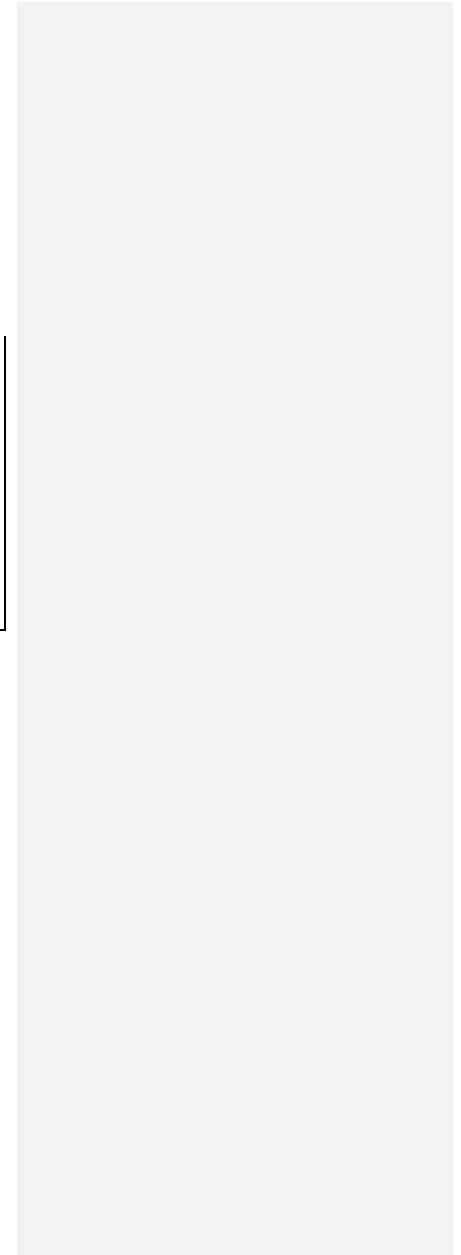
*Cumulative impact of HIV/AIDS morbidity + individual/household coping strategies*

<b>HIV/AIDS morbidity &amp; associated consequences</b>	<b>Potential coping strategies</b>	<b>Possible implications of coping strategies</b>
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<p><b>Community &amp; city level</b></p>	<ul style="list-style-type: none"> <li>• Higher disease burden</li> <li>• More + deeper levels of poverty + inequality; lack of food security</li> <li>• Reduced prospect of human devt. (poverty, loss of educational opportunities + income)</li> <li>• Entrenched gender relations + associated inequality</li> <li>• Pressure on community networks to provide for increasing demands in light of inadequacies of public sector</li> <li>• Stigma, fear + exclusion</li> <li>• Enhanced vulnerability to HIV infection</li> <li>• Reduced urban productivity</li> <li>• Possible out-migration/ slower rate of urbanisation</li> </ul>	<ul style="list-style-type: none"> <li>• The creation of systems of meaning that could either be inclusive or exclusive (i.e. 'othering')</li>   <li>• Social mobilisation on HIV/AIDS and/or related development issues (e.g. health care for PLWHA, shelter, education, women's rights)</li> <li>• Exclusion/discrimination</li> </ul>	<ul style="list-style-type: none"> <li>• Antagonism ('us'- 'them') or social cohesion?</li>   <li>• Vibrant civil society organisations + community structures involved in community development ('enhanced social capital'), or:</li> <li>• Over-extended, under-capacitated + under-resourced community groups</li> </ul>
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<p><b>Sector / institutional level</b></p>	<ul style="list-style-type: none"> <li>• Increased demand for more + qualitatively different services and support (in a potentially more conflict-ridden environment)</li> <li>• Increased absenteeism of HIV-infected/-affected public sector employees, eroding institutional capacity to provide quality services</li> <li>• Higher medical costs/health benefits for infected staff</li> <li>• Contraction of resource base due to reduced ability of affected households to pay revenues, user fees, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Attempt to meet demand (perhaps only partially), or:</li> <li>• Ignore demand (perhaps assume communities will step in?)</li> <li>• HR planning, e.g. retraining of staff or reassigning tasks?</li> <li>• ARV treatment for public sector employees + partners?</li> <li>• Increasing taxes and user fees?</li> </ul>	<ul style="list-style-type: none"> <li>• Financial + capacity implications</li> <li>• Reduced access to services of affected households (rights unrealised)</li> <li>• Higher medical costs for infected staff (cost-effective in longer term)</li> <li>• Reduced access to services of affected households (rights unrealised)</li> </ul>
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**Table 2. Impacts of HIV/AIDS-related mortality at individual, household, community / city and sector / institutional level in urban areas**

	<b>AIDS-related death</b>	<b>Potential coping strategies</b>	<b>Possible implications of coping strategies</b>
<b>Individual</b>	<ul style="list-style-type: none"> <li>• May result in poverty for other individuals (e.g. orphans, widows who lose assets), who may or may not be infected with HIV</li> <li>• Possible stigma, exclusion + discrimination for relatives of person(s) who died of AIDS-related illnesses</li> </ul>	<ul style="list-style-type: none"> <li>• Survivalist strategies: petty trading, sexual networking, joining youth gangs (as support networks), crime, etc.</li> <li>• Leave community, possibly to live on the streets or to return to rural areas (note: affected individuals from rural areas may migrate to urban areas)</li> </ul>	<ul style="list-style-type: none"> <li>• Enhanced risk of HIV infection</li> <li>• Homelessness</li> </ul>

<b>Household</b>	<ul style="list-style-type: none"> <li>•Widowhood + orphanhood</li> <li>•Funeral costs</li> <li>•Loss of household income/ livelihood</li> <li>•Loss of assets (e.g. house, land) + other forms of security</li> <li>•Breakdown of household structures + pressure on households to accommodate those affected by AIDS-related death</li> <li>•Possible stigma, exclusion or discrimination if HIV status is known or suspected</li> </ul>	<ul style="list-style-type: none"> <li>•Remarry (esp. men)</li> <li>•Diversion of hh income/ assets from needs of other hh members to funeral costs</li> <li>•Selling assets and borrowing (for funerals / income loss)</li> <li>•Income substitution, possibly through sexual networking</li> <li>•Return to rural areas for support</li> <li>•Formation of new forms of households: child-headed or multi-generational (grannies)</li> <li>•Attempt to conceal the nature of death because of associated stigma</li> </ul>	<ul style="list-style-type: none"> <li>•Possibility of HIV spread</li> <li>•Eroded asset base, debt, more/deeper poverty</li> <li>•Loss of nutrition (especially women and girls) + forfeited opportunities (e.g. education)</li> <li>•Loss of educational opportunities → implications for human devt (esp. girls) + ability to escape poverty</li> <li>•Risk of exploitation + abuse</li> <li>•Risk of STD/HIV infection</li> <li>•Fall through social safety nets because of dominant policy assumptions about hh</li> <li>•Social isolation</li> </ul>
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*Cumulative impact of HIV/AIDS mortality + individual/household coping strategies*

<b>HIV/AIDS mortality &amp; associated consequences</b>	<b>Potential coping strategies</b>	<b>Possible implications of coping strategies</b>
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<p><b>Community &amp; city level</b></p>	<ul style="list-style-type: none"> <li>• Increased adult + infant mortality (extent as yet unclear, as some urban residents likely to die in rural areas)</li> <li>• Collapse of family/hh structures due to disproportionate deaths of parents, leading to increased number of orphans, (with pressure on community safety nets to absorb them)</li> <li>• Enhanced poverty, inequality</li> <li>• Increase in homelessness + street children</li> <li>• Loss of productive members of community, undermining urban economy (implications for national economy)</li> <li>• Loss of those fulfilling leadership roles</li> <li>• Erosion of social and economic fabric</li> <li>• Reduced human development</li> <li>• Changing demographic profile (age, gender)</li> <li>• Possible slower rate of urbanisation, even outmigration?</li> </ul>	<ul style="list-style-type: none"> <li>• Systems of meaning (inclusive/compassionate or ‘othering’)</li> <li>• Absorption or exclusion of AIDS orphans, widows/widowers, bereaved parents?</li> <li>• Social mobilisation on HIV/AIDS and/or related development issues (e.g. orphans/street children, women’s rights, shelter, education, poverty, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Antagonism (‘us’-‘them’) or social cohesion?</li> <li>• Inclusive communities or eroded social fabric + exclusion?</li> <li>• Vibrant civil society organisations + community structures involved in community development (‘enhanced social capital’), or:</li> <li>• Over-extended, under-capacitated + under-resourced community groups</li> </ul>
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<b>Sector / institutional level</b>	<ul style="list-style-type: none"> <li>• Changing + increasing demand for services + support (e.g. child-headed hh)</li> <li>• Erosion of human resource capacity + organisational memory in city level organisations (sectors, municipal govt)</li> <li>• Increasing organisational costs into funerals, death benefits, replacement costs, etc.</li> <li>• Reduced local revenue base</li> </ul>	<ul style="list-style-type: none"> <li>• Attempt to meet demand (perhaps only partially), or: Ignore demand (perhaps assume communities will step in??)</li> <li>• Human resource planning?</li> <li>• Financial planning + resource mobilisation, or reactive spending?</li> <li>• Increasing taxes + user fees?</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced access to services by poor households + marginalised social groups (rights unrealised)</li> <li>• Reduced access to services by poor households + marginalised social groups (rights unrealised)</li> </ul>
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• Cumulative impact

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