

HIV/AIDS AND URBAN POVERTY IN SOUTH AFRICA

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1. Introduction

In South Africa, as in the rest of sub-Saharan Africa, HIV/AIDS is predominantly transmitted through sexual relations between men and women, which facilitates a secondary mode of transmission, namely from mother to child. Because HIV/AIDS attacks the immune system and leads to ill health and, ultimately, death, HIV/AIDS has initially been approached as a health concern. This emphasis on the health aspects of HIV/AIDS still dominates current policy debates on HIV/AIDS. There has also been a strong emphasis on curbing the spread of the epidemic. Because of the nature of HIV transmission in South Africa, prevention efforts tend to focus on changing sexual behaviour through the ABC of prevention: abstain, be faithful and use a condom. However, this approach assumes that sexual behaviour is a matter of rational individual choice. In reality, sexual behaviour is itself influenced by a range of factors, which include social, cultural, economic, political and technological factors. These factors further determine the extent to which people can access and use methods of HIV prevention, such as condoms, mutual faithfulness and abstinence.

The purpose of this paper is to explore HIV/AIDS as an urban development concern, with a particular focus on the link between HIV/AIDS and urban poverty. The next section looks at the concentration and manifestation of HIV/AIDS in urban areas. It examines why HIV/AIDS is concentrated in urban areas and which social groups are most vulnerable to HIV infection. In doing this, it highlights factors in the urban context that influence sexual behaviour and may constrain individual choice in sexual behaviour and access to HIV prevention methods. Poverty and inequality, particularly gender inequality, are identified as core factors in enhanced vulnerability to HIV infection. Section 3 discusses the relationship between urban poverty, inequality and HIV/AIDS in a bit more detail. In addition to recognising that urban poverty and inequality can enhance vulnerability to HIV infection, the paper discusses how urban poverty accelerates ill health and death due to HIV/AIDS and negatively affects the coping mechanisms of households affected by HIV/AIDS. But the relationship between poverty and HIV/AIDS is not just unidirectional. In looking at the impacts of HIV/AIDS in urban areas (in section 4), we find that HIV/AIDS has the potential to aggravate poverty by pushing more households into poverty and forcing poor households into deeper impoverishment. At the same time, the epidemic erodes the capacity of public sector institutions to deal with the increasing demand, as public sector personnel is also infected with and affected by HIV/AIDS. As such, this paper intends to demonstrate that HIV/AIDS is not merely a health concern, but in essence a development issue with the potential to undermine the prospect of urban development. The paper concludes with some recommendations on how to conceptualise a coherent and comprehensive approach to HIV/AIDS and urban poverty reduction.

2. The concentration and manifestation of HIV/AIDS in urban areas

In sub-Saharan Africa, the HIV/AIDS epidemic has historically concentrated in urban areas, where significantly higher HIV prevalence rates have been recorded than in rural areas. Although official statistics based on antenatal surveys do not disaggregate HIV prevalence in urban and rural areas, in South Africa HIV/AIDS is neither exclusively nor predominantly an urban issue. Instead, there is evidence of a parallel spread of the epidemic in urban and rural areas. This trend points to the complex and intricate linkages between urban and rural areas, particularly as embodied in the flows of people and the existence of multi-local households. However, closer scrutiny reveals that the HIV prevalence rate in urban areas is often higher compared to regional data. For example, based on the findings of the 2000 antenatal survey the Eastern Cape Department of Health has estimated that the average HIV prevalence rate in urban areas is 23.1% compared to 18.8% in rural areas in the province.¹ The City of Johannesburg

also recorded a higher than average HIV prevalence rate (26%, compared to a provincial rate of 24%), as did the City of Cape Town (8.1% in the Cape metropolitan area compared to a provincial HIV prevalence rate of 7.1%).² These figures suggest a higher concentration of HIV/AIDS in urban areas in South Africa.

There are a number of reasons that help to explain why HIV/AIDS is concentrated in urban areas:

- *Urban areas as centres of employment & income-generating opportunities*

Urban areas are both actual and perceived centres of employment and income-generating opportunities. As a result, many young adults (often male) migrate to urban areas in search of economic security. Historical factors also need to be taken into account. The migrant labour system was at the foundation of apartheid urban planning and led to the fragmentation of social structures and family life, especially amongst the African population.

Migration as a livelihood strategy is associated with higher levels of risk of HIV infection, because of the associated disruption of familial and spousal/sexual relationships. Data suggests that the HIV prevalence rate among South African migrants is higher than that among non-migrant counterparts in their areas of origin.³ However, recent research also warns against assuming that HIV transmission in migrant couples is unidirectional, in other words, the result of the (often male) migrant's sexual behaviour during periods of absence from his sexual partner in his area of origin.⁴ Clearly, the relationship between migration and HIV/AIDS is not simplistic.

Both the conditions during and after the journey put migrants at risk of HIV infection. Often, conditions in receiving areas are not adequate to deal with the influx, leading to overcrowding, inadequate provision of services and infrastructure, social isolation and frustration. In the absence of appropriate and affordable family housing, male migrants may end up in single-sex hostels. Moreover, urban areas may not bring the employment opportunities that migrants were hoping to find. Urban economies are particularly vulnerable to changes in the global and macro-economic environment. In recent years, highly skilled industries have largely benefited from processes of globalisation, whereas labour intensive-industries dependent on low-skilled and semi-skilled labour have declined. The volatility of the economy directly affects employment prospects in urban areas. Endemic unemployment is likely to enhance feelings of social disillusionment, frustration and boredom, which could discourage safe sex, especially when immediate survival needs are more urgent than the long-term and invisible threat of ill health and death due to HIV/AIDS.

Migration alters the composition of urban areas in terms of age and sex, with the majority of migrants being young adults (15-49 years old) and male. In South Africa, the four most urbanised provinces show a higher than average (i.e. above 48%) proportion of men.⁵ This reality encourages another livelihood strategy, namely sexual networking, which includes commercial sex work and sex in exchange for money, goods or protection. Sexual networking clearly points towards a situation of unequal power relations, if not powerlessness, where it is highly unlikely that safe sex can be demanded. Because the reward for unprotected sex is usually higher, the use of condoms in these sexual transactions is discouraged.

- *Urban areas as centres of services*

Urban areas also attract people, because of the expectation that there will be improved access to and better quality of services, such as housing and basic services, education, health care and welfare facilities. The inadequacies of public services and lack of infrastructure development in rural areas can serve as a 'push' factor. Although there is as yet no research that suggests that people infected and affected by HIV/AIDS move to urban areas in the hope of accessing better services, the fact that even basic medicines

and health care are lacking in most rural clinics suggests that this could be a factor. Clearly, more research is needed to investigate this.

Whereas urban areas generally have higher levels of public services, these services are not necessarily accessible to and affordable for all urban residents. Again, the apartheid policy of non-provision to or limited development of certain residential areas in urban centres has left a legacy of inequitable service provision and significant service delivery backlogs. Current public services are not necessarily sufficient to address these backlogs, let alone accommodate increasing demand. Also, what is frequently overlooked is the fact that the higher cost of living in urban areas means that poor households are often unable to take advantage of public services, especially when a household contribution is required. Furthermore, poor and low-income households often have to make a choice between quality of services and proximity to economic opportunities. For example, new housing developments are generally located on the periphery of urban areas, far from employment opportunities or social facilities, and without adequate and affordable public transport. As a result, some poor households opt to stay in (or even return to) informal settlements characterised by poor environmental conditions and lack of infrastructure development, because these are more centrally located. As highlighted before, these conditions are conducive to the spread of a sexually transmitted epidemic.

• *Urban areas as centres of social dislocation, exclusion and inequality*

Globally, inequality is generally greater in urban areas, both with respect to income and in terms of the quality of life. This suggests that if one is not successful in accessing work opportunities and public services in urban areas, there is a significant risk of social and economic exclusion. Current urban realities in South Africa attest to this dichotomy between the prospects of a better life and the ability to benefit of those prospects. It is widely recognised that HIV/AIDS follows social divisions and patterns of inequality, with factors like gender and socio-economic status having particular relevance in the South African context.

In the context of HIV/AIDS, gender inequality implies that women have a lack of negotiating power in sexual relations and with regard to sexual behaviour. For many South African women, it is impossible to insist on safe sex with their husbands or boyfriends. Also, as the high prevalence of rape highlights, forced sex is a reality for many South African women. Women in urban areas are particularly vulnerable, with a significantly higher level of women abuse and rape in urban areas (5.0%) compared to rural areas (3.6%).⁶

Poverty is also a significant factor in the spread of HIV/AIDS. International evidence suggests that there is a close correlation between poverty and HIV/AIDS, with the poor constituting the absolute majority of those living with HIV/AIDS. However, the relationship between poverty and HIV/AIDS is not simplistic. Although the majority of people living with HIV/AIDS are poor, not all poor people are HIV-positive and a significant number of middle class people are infected with HIV. Thus, poverty should be seen as a co-factor among other factors. In fact, many have argued that it is more appropriate to identify inequality underpinning poverty as a core factor in the transmission of the HIV/AIDS.

Although there is no official data on HIV prevalence rate by income groups in South Africa, local evidence suggests that HIV/AIDS is concentrated in townships and informal settlements, with communities like Soweto, Walmer Estate (in Port Elizabeth) and black communities in Cape Town showing higher HIV rates compared to other parts of the same urban area.

There are various ways in which poverty facilitates the transmission of HIV/AIDS. For example, evidence suggests that there is a correlation between levels of education, fertility and condom use. This shows that those with higher levels of education are more

able to prevent risk of HIV transmission. Poverty, particularly income poverty, also forces people to engage in survival strategies that put them at risk of HIV infection. The two most significant strategies in this respect are migration and sexual networking, which have been discussed already. Poverty at community level also enhances the risk of HIV infection. For example, the treatment of sexually transmitted infections can significantly reduce the risk of HIV infection. Yet, in many poor communities, basic health services are lacking or inadequate and such preventative treatment is not accessible. Similarly, condoms may not be freely available, which puts prevention beyond the means of poor urban households. Furthermore, overcrowding, lack of infrastructure and services breed social pathologies like violence and crime, which also express themselves in sexual behaviour (e.g. rape and incest). As highlighted before, in contexts where immediate survival needs are more pressing than the long term threat of ill health and death caused by an invisible virus, there is little incentive to practise safe sex. Poverty also constrains the prospect of reducing the risk of HIV transmission from mothers to their babies, not only because of a lack of antiretroviral treatment in public hospitals, but also through the lack of clean water for breast-milk substitutes. In general, poverty is characterised by a lack of power and resources to exercise informed choice and prevent the risk of HIV infection.

- *Urban areas as centres of social change*

Urban areas often host a variety of people from different social, cultural, religious, economic and political backgrounds. The interaction with people from different backgrounds, coupled with the distance from traditional forms of influence and control, and the possibility to remain invisible and anonymous (possibly combined with the financial ability to adopt different lifestyles), can result in a change in social norms, values and practices, including those in relation to sexual behaviour.

Manifestation of HIV/AIDS in urban areas

The preceding discussion has sought to explain why HIV/AIDS is concentrated in urban areas. However, not all social groups in urban areas are equally vulnerable to or affected by HIV/AIDS. Although there is no specific data on the manifestation of HIV/AIDS in urban areas in South Africa, national and international data suggest that certain social groups are more vulnerable to HIV infection and the effects of HIV/AIDS related illness and death. These include:

- Young adults (15-49 years old), but specifically women in their twenties and men in their late twenties-early thirties, as these are the majority of sexually active people and also the majority of migrants;
- Women, both for biological and sociological reasons (i.e. the socio-economic status of women and the pervasiveness of gender inequality);
- Low-income / poor people, who are least likely to have the means, knowledge and power to prevent HIV infection;
- Illegal immigrants, who are unable to access public services. Most illegal immigrants tend to be single men, who may purchase sex. Where it concerns women, they may resort to prostitution in order to survive.
- Sex workers, because the illegality of their work prohibits protective sexual behaviour.
- Infants, who are vulnerable to HIV infection via mother-to-child transmission.

Clearly, the overlap between factors like age, gender and socio-economic status creates a context of compounded vulnerability, with poor black young women being most at risk of HIV infection. The exact nature of vulnerability depends on the local context, which points to the need for local data that is disaggregated according to age, gender, socio-economic status and population group and for a proper analysis of relevant local trends. One of the challenges in accessing and interpreting local data is to prevent equating risk with responsibility. In other words, as the preceding discussion has sought to highlight, many so-called 'risk groups' have limited power and resources to prevent HIV infection.

Without recognising the broader socio-political context in which people live, act and behave sexually, there is a danger of perpetuating the stigma associated with HIV/AIDS.

2. HIV/AIDS, urban poverty and inequality

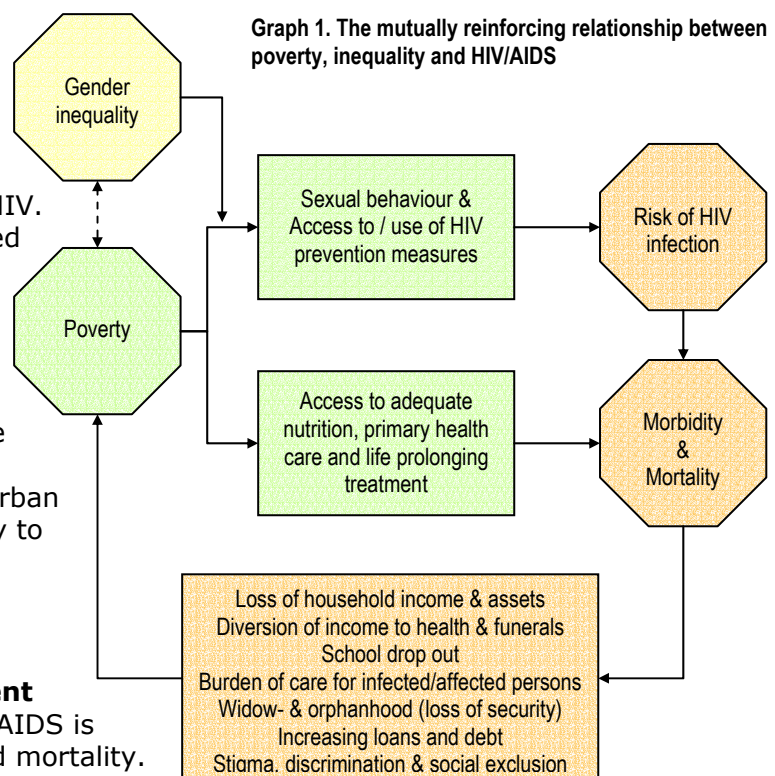
The preceding section has touched on the link between poverty in urban areas and HIV/AIDS and highlighted ways in which poverty increases the risk of HIV infection. But poverty does not only increase vulnerability to HIV infection, it also reduces the capacity of people living with and affected by HIV/AIDS to cope with the consequences of infection. HIV/AIDS is associated with repeated bouts of illness, which tend to last longer as the immune system gets more and more eroded. The lack of adequate nutrition significantly reduces resistance and accelerates ill health and death. Moreover, poor urban households are less able to access appropriate health care services, either because the available services lack the resources (including medicines and human resources) to provide effective health care, or because a household contribution is required, or because public transport to these services is inadequate or unaffordable for poor households.

As mentioned before, there is evidence that HIV/AIDS follows the social fault lines in a society, with marginalized groups being disproportionately vulnerable to HIV/AIDS. In a context of a sexually transmitted epidemic, gender inequality clearly is a core factor determining vulnerability. Like poverty, gender relations not only influence people's ability to choose responsible sexual behaviour and decide on the appropriate risk prevention method, gender imbalances also influence their capacity to cope with the consequences of HIV infection. Women often prioritise the well-being of other family members at the expense of their own health and well-being. Thus, male members of a poor household tend to be the first to receive food, with what is leftover shared between women and children. This compromises the nutritional intake of women, thereby leaving them more susceptible to ill health and death as a result of HIV/AIDS. Research from Côte d'Ivoire and Thailand shows that more money is spent on health care for men living with HIV/AIDS than on women with HIV/AIDS.⁷ There are also indications that South African women, particularly poor black women, do not receive the same quality treatment as men or white South Africans when they finally do seek health care.

So far, we have discussed how poverty and inequality, specifically gender inequality, enhance vulnerability to HIV infection and reduce one's capacity to cope with the consequences once infected with HIV. At the same time, HIV/AIDS-related ill health and death has the potential to further aggravate urban poverty and inequality. Graph 1 captures this vicious cycle between poverty, inequality and HIV/AIDS in graphic form. The next section will elaborate on the multiple impacts of HIV/AIDS on urban development, including its capacity to exacerbate urban poverty and inequality.

3. The multiple impacts of HIV/AIDS on urban development

The primary manifestation of HIV/AIDS is increased morbidity (ill health) and mortality.



The immediate impact is felt at household level, where medical costs and funeral costs add a significant burden to the household budget. At the same time, because HIV/AIDS generally affects young adults and productive members of the household, repeated periods of ill health and death of these providers will reduce household income. To cope with the dual impact of loss of income and increasing costs associated with HIV/AIDS, poor households are often forced to sell of their assets, take on increasing debt and take children out of school (because they cannot afford to pay school fees or other costs associated with education and/or because these children need to look after sick relatives or substitute for lost income). Where education is forfeited, future prospects for human development and employment are thwarted, which seriously limits the possibilities for these children to move out of poverty as adults. The death of a husband and father often means a loss of assets and other forms of security for women, children and the elderly. In summary, poor households affected by HIV/AIDS are likely to be pushed into deeper poverty, whereas households hovering above the poverty line will lose the fragile security they had and end up below the poverty line. As a result, social divisions and inequality will be reinforced.

In fact, the whole notion of households will be under threat, with an increasing number of single-parent households, child-headed households, households made up of a mix of first and third generations (i.e. elderly and youth) and other forms of extended, mixed households. Also, there will be a significant increase in the number of orphans. Many community support structures to look after these children are already stretched to the limits and with the stigma associated to HIV/AIDS, many orphans could end up having to fend for themselves.

As the epidemic progresses, and in particular as more and more people reach the stages of HIV/AIDS-related illness and death, the impact of HIV/AIDS transcends the household level. Over time, changes in the demographic composition of urban areas will be evident. The disproportionate numbers of death among young adults means that there will be a higher proportion of youth and elderly people. The gender ratio may also change, with men increasingly outnumbering women in urban areas. However, a lot remains unclear about the future composition of urban areas, as it is still uncertain how HIV/AIDS will affect migration and settlement patterns. It is quite likely, though, that an increasing number of orphans from rural areas will move to urban areas, seeking to escape social exclusion and destitution in their communities of origin. In the absence of adequate support services to receive these children, the majority of them is likely to end up on the streets.

The health care system is amongst the first sectors to experience the impacts of the epidemic, with an increased demand for treatment (of opportunistic diseases, like tuberculosis, but also for antiretroviral drugs) and care. Many hospitals in worst affected areas in South Africa are experiencing serious overcrowding as a direct result of the HIV/AIDS epidemic. However, due to a lack of medicines (ranging from antiretroviral treatment to basic medicines), personnel and resources, local clinics are often unable to provide the required services. At the same time, health care personnel is not unaffected by HIV/AIDS. In fact, a significant number of health care workers is estimated to be HIV-positive. As a result of increasing levels of sickness and death among health care workers, the institutional capacity to deliver quality health care services is being eroded.

Similar effects are visible on other sectors. For example, there is likely to be less demand for education as an increasing number of children is taken out of school to assume 'adult' roles in poor households. Orphans are particularly at risk of dropping out from school. At the same time, the increased morbidity and mortality among teachers will also negatively affect the quantity and quality of education. Other sectors that have been identified as being particularly susceptible to the impacts of the epidemic include the police and armed forces and economic sector like the mining sector and the transportation sector.

Of particular concern is the negative impact of HIV/AIDS on the urban economy. Because the majority of those living with HIV/AIDS are between 15-49 years old – those considered to be the backbone of the local economy – increasing levels of ill health and death will seriously compromise productivity. In addition to a loss of personnel and skills, which is often costly to replace, there will be a loss of organisational memory and experience, which is not easy to replace. The exact impact on the urban economy depends to a certain extent on the economic base of the city. Yet, all companies and sectors (including government) are likely to face higher costs for replacement, training, benefits and absenteeism. Because urban areas in South Africa make such a significant contribution to the national economy (80% of GDP)⁸, reduced productivity and economic costs associated with HIV/AIDS will not be restricted to the urban economy, but will have macroeconomic implications.

The cumulative impact of HIV/AIDS puts further stress on political and administrative systems responsible for urban development. With the public sector itself badly affected by the loss of skilled and experienced personnel, its capacity to deliver basic services and improve the quality of life of urban residents on an equitable basis is severely compromised. This occurs against the backdrop of increasing demands for more basic services and for qualitative different services to assist poor households to cope with the devastating effects of HIV/AIDS. For example, there will be increasing demand for welfare facilities and for a greater variety of social security mechanisms to support individuals, households and communities affected by HIV/AIDS. There will also be a need for housing to be adapted to the needs of bedridden and wheelchair-bound people living with HIV/AIDS and for housing subsidies to be made available to cover such expenses.

When the public sector is unable to provide the services and support required, the responsibility to look after those who are sick, dying or left behind will, once again, fall on women, children, the elderly and poor households in general. This is likely to enhance inequality, especially given the stigma associated with HIV/AIDS. People with HIV/AIDS, those suspected of being HIV-positive or those related to someone living with HIV/AIDS are likely to experience social exclusion and stigma.

HIV/AIDS and urban development: some implications for interventions

The preceding discussion has painted a rather gloomy picture of the devastating impacts of HIV/AIDS in urban areas. This reality poses a significant challenge to all actors involved in urban development to confront HIV/AIDS as an integral component of urban development. Municipalities, as key actors in urban development, have in the main been slow to appreciate the way in which the epidemic increases urban poverty and inequality and erodes institutional capacity for development. Thus, few municipalities have developed a comprehensive and multi-faceted strategy that includes prevention, treatment/care and impact mitigation and that combines a service delivery focus with a focus on the organisation (human resources). However, from an anti-poverty perspective, all these elements of an HIV/AIDS Programme are important. Fortunately, there is some evidence that urban municipalities are starting to recognise the broader implications of HIV/AIDS and are developing more comprehensive approaches to the epidemic. Box 1 gives an example of recent innovative urban planning to respond to the different demands stemming from the HIV/AIDS epidemic.

Box 1. Housing and AIDS

Planners in Nkwazi in KwaZulu-Natal, South Africa, have attempted to anticipate the effects of HIV/AIDS. Instead of scattered box houses on grids of roads, they have designed narrow plots facing articulated pedestrianised areas as part of a cooperative low-cost housing scheme. This enhances the possibility of surveillance of the common area. The fact that people are living closer to each other facilitates social support and networking. The same architects have proposed building incremental ablution areas which can be improved over time and which will offer facilities at late stage illness including wheelchair access.

Source: UNDP (2001), *HIV/AIDS: Implications for Poverty Reduction*, Background paper prepared for the UN General Assembly Special Session on HIV/AIDS, UNDP, New York, p. 15

Because of the complex and multi-faceted nature of HIV/AIDS, a coordinated response between various actors in urban development is required. Thus, there is a need for a multi-sectoral and multi-level response that allows for coordination and policy coherence between different government departments, within municipalities and between the different spheres of government. As a consequence, some institutional form of coordination and integration in planning and budgeting systems will be required.

To sum up, an effective approach to HIV/AIDS in urban areas is:

- Context-specific, i.e. informed by an understanding of local realities and trends;
- A combination of prevention, treatment/care and impact mitigation;
- Multi-sectoral, multi-level and integrated;
- A combination of bottom-up and top-down approaches;
- Inclusive of all stakeholders, especially people who are infected and affected by HIV/AIDS and their representative organisations, at all levels of policy formulation, programme design and evaluation;
- Based on learning by doing, because of the many unknown and unpredictable factors, which points to the importance of a monitoring and evaluation system;
- Two-pronged, namely both an internal (workplace) and external (service delivery) focus, based on an understanding that these two dimensions are interlinked and influence each other.

A comprehensive HIV/AIDS approach can make a meaningful contribution to urban poverty reduction. The opposite is also true: poverty reduction and increased economic empowerment could enhance the capacity of poor urban households and communities to cope with HIV/AIDS. It could also allow people a greater degree of self-control over their lives, specifically in sexual encounters. However, it is worth noting that poverty is only one among multiple factors that facilitate the spread of HIV/AIDS. In particular, if poverty reduction strategies result in a situation where gender disparities are aggravated rather than reduced, it is quite likely that the epidemic will not be curbed. For example, if poverty reduction strategies aimed at income generation, consciously or not, target men at the exclusion of women, the economic and political powerlessness of women is likely to be enhanced. This could entrench a situation where sex is a commodity in exchange for money, goods or protection and where women are unable to negotiate safe sex. This points to the importance of gender analysis in the formulation of poverty reduction strategies and the need for effective monitoring and evaluation systems.

Conclusion

This paper has sought to highlight that HIV/AIDS is an urban development issue for reasons related to its concentration in urban areas, its close interrelationship with urban poverty and inequality, and its ability to erode institutional capacity for urban development, thereby undermining the prospects of equitable urban development. As such, it has advocated a shift from focusing on the epidemiology of HIV/AIDS to the social, political and economic context in which the epidemic occurs. Whereas the tenor of the paper may have been quite alarming, there is still a significant window of opportunity for key actors in urban development to curb the spread of HIV/AIDS, provide adequate care and treatment to people infected with HIV, affirm their dignity, and put mechanisms in place to deal with the devastating socio-economic impacts of the epidemic. In particular, a conscious attempt to reduce poverty and inequality in order to lessen vulnerability and the negative effects of HIV/AIDS and, vice versa, to address HIV/AIDS in its complexity in order to overcome poverty, marginalisation and inequality, is an essential step in ensuring an improved quality of life for all urban residents on an equitable basis.

Box 2. The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa

The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa was formed in 1997. The overall goal of the Alliance is to promote actions that contribute to limiting the spread of HIV and alleviating the social and economic impact of the epidemic on communities in Africa. It was formed to promote an expanded, multi-sectoral response to the epidemic at local level, and works in partnership with government, civil society organizations, the private sector and local communities.

South Africa is one of the countries that have launched a National Chapter of the Alliance. This took place in Durban, towards the end of 2000. However, due to the municipal elections and the process of institutional restructuring following the elections, the initiative has as yet not gained much momentum. Recently, efforts have been made to revive the initiative at a small scale, with coordinating responsibility being located with SALGA.

With support from UNDP and UNAIDS, the Alliance has developed a strategy: the Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level (AMICAALL). AMICAALL is designed to be inclusive, responsive, gender sensitive and dynamic. It aims to strengthen local capacities to manage a coordinated, multisectoral response based on complementarity.

In 2001, the UN-AMICAALL Partnership Programme was launched, which works in collaboration with UNAIDS, other UN organisations, bilateral agencies, foundations, the private sector and non-governmental organisations.

Resource mobilisation and partnership development are a key focus for both the Alliance and the UN-AMICAALL Partnership Programme. As such, both could be useful entry points for urban municipalities and the South African Cities Network seeking to expand their response to HIV/AIDS.

More information can be obtained from the website (www.amicaall.org) or the following contact persons:

- Mr. T. Parker, Acting Administrative Officer, Alliance Secretariat, PO Box 60401, Katatura, Windhoek, Namibia, Tel (+264) 61 224730, Fax (+264) 61 227890, Email: alliance@iway.na
- Ms. M. Mauerstein-Bail, Director, UN- AMICAALL Partnership Programme, 11-13 chemin des Anémones, CH-1210 Châtelaine, Geneva, Switzerland, Tel (+41) 22 917 8597, Fax (+41) 22 917 8078, Email: mina.mauerstein-bail@undp.org

Useful resources

Websites

Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa and the Alliance of Mayors' Initiative for Community Action on AIDS at Local Level (AMICAALL): www.amicaall.org

UNAIDS Best Practice Collection: www.unaids.org

For further reading

Health Economics HIV/AIDS Research Division (2001), *Revised HIV/AIDS Toolkit for Local Government*, HEARD, University of Natal, Durban

Rajaraman, A. (2002), *An Inventory of Urban and Local Government Actions to Address the Impacts of HIV/AIDS*, United States Agency for International Development (USAID), Regional Urban Development Office/Sub-Saharan Africa, Pretoria

United Nations Development Programme (UNDP) Regional Project on HIV and Development (2002), *Conceptual Shifts for Sound Planning: Towards an Integrated Approach to HIV/AIDS and Poverty*, UNDP Regional Project on HIV and Development, Pretoria (forthcoming)

Urban Management Programme (UMP) (2002), *The Management of the HIV/AIDS Pandemic at the Local Level*, Paper prepared for the World Urban Forum, United Nations Human Settlements Programme (Habitat), Nairobi, 29 April – 3 May 2002
UNAIDS (2002), *Report on the Global HIV/AIDS Epidemic 2002*, UNAIDS, Geneva
Van Donk, M. (2002), *The Missing Element: HIV/AIDS in Urban Development Planning. Reviewing the South African Response to the HIV/AIDS Epidemic*, Working Paper No 118, The Development Planning Unit, University College London, London
Van Rensburg, D. et al. (2002), *Strengthening Local Government and Civic Responses to the HIV/AIDS Epidemic in South Africa*, Centre for Health Systems Research & Development, University of the Free State, Bloemfontein

¹ Eastern Cape Department of Health (2001), 'HIV and Syphilis Survey: Provincial Report', *Eastern Cape Epidemiological Notes*, No 14, April 2001, Epidemiology and Research Unit, Eastern Cape Department of Health.

² Sources: City of Johannesburg (2001), 'What Can the City Do for You? – Health' [<http://www.goafrica.co.za/joburg/services/healthh1.stm>] and Thomas, E and Crewe, M (2000), 'Local Authority Responses to HIV/AIDS: An Overview of a Few Key Cities', *Urban Health and Development Bulletin*, Vol 8 No 2, 9-30.

³ See, for example, Lurie, M. et al. (2002), 'The Impact of Migration on HIV-1 Transmission in South Africa: A Study of Migrant Men and Their Partners and Non-Migrant Men and Their Partners', in *Sexually Transmitted Diseases* (in press); Lurie, M. et al. (2000), *Migration and the Spread of HIV in Southern Africa: Prevalence and Risk Factors among Migrants and their Partners, and Non-Migrants and their Partners*, MRC, Cape Town.

⁴ For a discussion of the sexual behaviour of female partners of migrants in KwaZulu Natal, see Dladla, A.N. et al. (2001), 'Speaking to Rural Women: The Sexual Partnership of Rural South African Women Whose Partners are Migrants', in *Society in Transition*, Vol 31 No 1, pp. 79-82. 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, D. et al. (2002), *Strengthening Local Government and Civic Responses to the HIV/AIDS Epidemic in South Africa*, Centre for Health Systems Research & Development, University of the Free State, Bloemfontein).

⁵ The four most urbanised provinces are Gauteng (96.5%), the Western Cape (88.9%), the Free State (70.5%) and the Northern Cape (68.8%) (South African Institute for Race Relations (2001), *South Africa Survey 2000/2001*, South African Institute for Race Relations, Johannesburg, p. 61).

⁶ Based on statistics from the Department of Health. Quoted in Van Rensburg D. et al. (2002).

⁷ UNAIDS (Joint United Nations Programme on HIV/AIDS) (2002), *Report on the Global HIV/AIDS Epidemic, June 2002*, UNAIDS, Geneva, p. 49.

⁸ Department of Housing (1997), *Living Cities: Urban Development Framework*, Department of Housing, Pretoria, p. 2.