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THE MISSING ELEMENT: HIV/AIDS IN URBAN DEVELOPMENT PLANNING REVIEWING THE SOUTH AFRICAN RESPONSE TO THE HIV/AIDS EPIDEMIC

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INTRODUCTION

Research for this paper started from the premise that in South Africa HIV/AIDS [1]is predominantly construed as a health issue and that, as a consequence, urban development planning is not sufficiently taking into account the destabilising effects of the HIV/AIDS crisis on the social fabric in communities, on political participation and on the urban economy.

To investigate this proposition, I first embarked on a process of investigation into how HIV/AIDS is presented in international development debates and found that the medical bias has also prevailed there. Increasingly, though, as the epidemic progresses and its devastating impacts start to become visible to policy makers, there is a shift from a medical conceptualisation of HIV/AIDS to a recognition that HIV/AIDS is a development concern. Chapter 1 and 2 elaborate on what this means. Given that the epidemic in most developing countries is concentrated in urban areas, the implications for urban development are significant. Yet, a further step in my investigation showed that there is a paucity of data on the nature and manifestation of HIV/AIDS in urban areas and, subsequently, a lack of analysis on the relevance of the epidemic for urban development planning. Clearly, the conceptual framing of HIV/AIDS as a medical issue has contributed to this omission. Other reasons for this oversight relate to the invisibility of the epidemic, the politically sensitive nature of HIV/AIDS and the complexity of the issue. Furthermore, the epidemic is not occurring in a vacuum, but has inserted itself into a domain already characterised by great complexity.

This led me to the next step in my exploratory process, which was to assess whether mainstream urban development planning has been successful in addressing the increasing complexity of urban development. The answer to this question, I thought, would help me to better understand why urban development planning is silent on HIV/AIDS and what could be done to break this silence.

Reviewing the whole terrain of urban development planning, both in relation to policy and practice, is a monumental task and clearly beyond the scope of this paper. By default, the analysis presented here is partial. For the purpose of this paper, my main interest was to establish whether urban development planning has been effective in responding to inequality in a context characterised by rapid change. Concluding that this is not the case, I proceeded to explore what normative framework could be introduced to overcome the inability of mainstream urban development planning to address inequality. In comparing the 'good city', as explicated by John Friedmann, and the 'just city', as advocated by Susan Fainstein, I concluded that a refined just city model would be most appropriate to guide urban development planning in developing countries. Chapter 1 therefore ends with the articulation of seven inter-related just city principles.

In Chapter 2, I set out to investigate the interplay between HIV/AIDS and inequality and found that this relationship is bi-directional. On the one hand, HIV/AIDS follows existing patterns of inequality and vulnerability (although not exclusively). On the other hand, HIV/AIDS entrenches social divisions, reinforces inequality and enhances impoverishment. This begged the question whether the just city can be achieved in the context of the HIV/AIDS epidemic or, alternatively, whether the just city can create the conditions for an effective response to HIV/AIDS. I concluded that to a certain extent the just city can create an environment in which vulnerability to HIV/AIDS is reduced and the impacts of HIV/AIDS are better addressed. However, I felt that this in itself would not be sufficient to respond to the complex challenges posed by HIV/AIDS. Instead, I suggest that the just city principles themselves need to be interpreted in such a way that takes account of the nature and manifestation of HIV/AIDS in urban areas. Chapter 2 concludes with some suggestions on how to 'read' the just city principles through an 'HIV/AIDS lens'.

After exploring the international literature on HIV/AIDS and urban development and introducing the just city as a normative framework to guide urban development planning, time had come to locate these findings and arguments in a specific socio-political and historical context. I chose South Africa, partly because it has the highest absolute number of people living with HIV/AIDS and because urban development planning is currently under review. In analysing the specific historical, social, political and economic factors that shape the HIV/AIDS epidemic in South Africa's towns and cities, I found that apartheid urban planning has been a significant factor in the spread and manifestation of the epidemic. Whereas the

two most significant urban development policy frameworks recognise the imprint of apartheid urban planning on the urban landscape and are concerned with overcoming this legacy, they remain silent on HIV/AIDS. In the absence of an explicit recognition of HIV/AIDS as an urban development concern in these policies, I sought to explore whether there is sufficient overlap between the South African policy frameworks and the just city model to allow for an insertion of HIV/AIDS into urban development planning. I came to the conclusion that the compatibility between the South African visions for urban areas and the just city principles provides an opportunity to incorporate HIV/AIDS into urban development planning, provided these principles are interpreted in such a way that recognises the nature and manifestation of HIV/AIDS in urban areas. In concluding Chapter 3, I argue that it is both necessary and possible to take account of HIV/AIDS in urban development planning in South Africa. As a first step, what is required is a recasting of HIV/AIDS as a development concern and not merely a health issue.

Before concluding this introduction, a few preliminary comments need to be made. This paper is chiefly concerned with urban planning in developing countries. The focus on developing countries in general terms is not to assume that developing countries constitute a uniform entity, nor to deny the interdependence of industrialised and developing countries or the "highly interrelated and interdependent nature of the urban process" (Potter and Lloyd-Evans, 1998, p. 22) in countries with differential levels of development. Nor does it mean to suggest a high level of uniformity within a developing country. However, it is argued that it is justified to focus on developing countries as a distinct – though heterogeneous – group of countries, based on certain commonalities vis-à-vis their historical and contemporary relation to the international system, which is characterised by structural disadvantage, poverty and inequality. Although comprising 75 percent of the world's population, they account for only 15 percent of the world's income and 20 percent of global energy consumption (Ibid, p. 25). In addition, in contrast to developed countries, they are characterised by rapid urban growth, which is "occurring in a context of far higher absolute population growth, at much lower income levels, with much less institutional and financial capacity and with considerably fewer opportunities to expand into new frontiers" (UNCHS, 2001, p. 3). It is the combined effect of historical disadvantages, reinforced in current global systems, and current demographic trends that result in particular urban development challenges in developing countries.

Moreover, the focus on developing countries is further narrowed to refer to countries in sub-Saharan Africa in particular, because this is where the AIDS epidemic is reaping its highest toll. By concentrating on sub-Saharan Africa, this paper deals with HIV/AIDS as a heterosexually transmitted epidemic.[2] This focus on heterosexually transmitted HIV infection is not to suggest that homosexuality or drug injection are insignificant factors of vulnerability, nor to ignore that these factors are associated with social division and stigmatisation. However, in the context of sub-Saharan Africa, these factors are less pertinent.

A final comment needs to be made regarding the availability of data. My investigation was hindered by the lack of reliable data and analysis, both in relation to international HIV/AIDS projections and in relation to South Africa. Because the epidemic is still evolving, most data is based on modelling techniques and projections rather than measured outcomes (Whiteside and Sunter, 2000). Furthermore, the accuracy of data is compromised by the possibility of under-reporting. In some instances, the lack of international and South African data can be attributed to similar reasons, whereas in other instances they are specific to the South African context. What is clear, though, is that many aspects of the HIV/AIDS epidemic are under-investigated, particularly from a social sciences perspective. It is hoped that this paper will contribute to this research gap, albeit in a small way.

1. HIV/AIDS IN THE CONTEXT OF URBAN DEVELOPMENT COMPLEXITY: THE JUST CITY AS AN ALTERNATIVE NORMATIVE FRAMEWORK FOR URBAN DEVELOPMENT PLANNING

"HIV/AIDS has become a global crisis. The epidemic kills millions, destroys families and communities and renders millions of children parentless. It threatens the social and economic fabric of many nations. Respecting, protecting and fulfilling the human rights of all individuals is indispensable to reducing the rates of infection, expanding access to care and treatment and mitigating the impact of the epidemic" (UNGASS, 2001a, p. 6).

Introduction

HIV/AIDS is a global crisis, which disproportionately affects urban areas in developing countries, in particular in sub-Saharan Africa. The first part of this chapter outlines the scale and features of HIV/AIDS in urban areas in developing countries. The association of HIV/AIDS with socially marginal groups suggests that inequality is a significant factor in explaining vulnerability to HIV infection. It is also intimated that HIV/AIDS is undermining the prospect of urban development. Yet, neither the causes of vulnerability to HIV infection nor the impacts of HIV/AIDS have been sufficiently recognised in mainstream approaches to the epidemic. This partly explains the silence on HIV/AIDS in urban development planning. This chapter seeks to locate HIV/AIDS within the context of ever-increasing complexity that characterises urban development in developing countries. Drawing on current debates, I define urban development as a multi-dimensional process aimed at enhancing the quality of life and equality within and between urban areas. After reviewing numerous inadequacies of urban development planning in relation to the different dimensions of urban development, I suggest that a central failure of mainstream urban development planning in developing countries is its inability to effectively address inequality. In an attempt to overcome this weakness, I explore to what extent the utopian images of John Friedmann's 'good city' and Susan Fainstein's 'just city' provide useful normative frameworks. After discussing these models, I suggest that the notion of the just city is more powerful and appropriate within the context of developing countries. The chapter is concluded by articulating seven inter-dependent principles of a just city.

Scale And Features Of HIV/AIDS In Urban Areas

In 1981, AIDS was first recognised as a distinct clinical syndrome (Farmer, 1996). Since then, close to 60 million people have become infected with HIV, of which almost 22 million have died of AIDS[3] (UNAIDS, 2000a). Almost 95% of those living with HIV/AIDS live in developing countries (Collins and Rau, 2000). As Table 1.1 shows, about 70% live in sub-Saharan Africa.[4] Every day, approximately 15 000 people get infected with HIV (Ibid). Sub-Saharan Africa accounts for close to three quarters of these new infections, followed by Asia with 17% (see Table 1.1).

Table 1.1 Global HIV/AIDS Statistics and Features

Region	People living with HIV/AIDS in 2000	New HIV infections in 2000	AIDS deaths in 2000	Main modes of transmission*
Sub-Saharan Africa	25.3 million	3.8 million	2.4 million	Hetero
North Africa & Middle East	400 000	80 000	24 000	Hetero, IDU
Latin America & Caribbean	1.8 million	210 000	82 000	Hetero, MSM, IDU
Asia	6.4 million	910 000	495 000	Hetero, IDU, MSM
Transitional countries	700 000	250 000	14 000	IDU
Industrialised countries	1.5 million	75 500	27 000	MSM, IDU, Hetero
Total	36.1 million	5.3 million	3.0 million	Hetero, MSM, IDU

*** Hetero: heterosexual transmission; IDU: transmission through injecting drugs use; MSM: sexual transmission among men who have sex with men**
Source: UNAIDS/WHO (2000)

The majority of those infected are young adults, between the ages of 20-40 (Panos, 1992; Carballo and Careal, 1988). In fact, half of all new HIV infections occur amongst those between 15-24 years old (Baylies, 2000a, p. 10). In countries where HIV is largely heterosexually transmitted, women tend to outnumber men amongst HIV-positive people.[5] In 1999, 55% of infections in sub-Saharan Africa occurred among women (Collins and Rau, 2000, p. 1). In other words, for every ten men that get infected in Africa, 12 to 13 women are being infected. Women also tend to be younger than men when they get infected. According to Barnett and Blaikie (1992, p. 34), the majority of HIV-positive women in Africa are between 20-29, compared to HIV-positive men who are between 25-34 years old. Where the epidemic is heterosexually transmitted, babies are increasingly infected through mother-to-child transmission (MTCT)[6] (Collins and Rau, 2000, p. 1).

Initially, the virus disproportionately affected the educated skilled labour force, which tended to have higher levels of mobility and more disposable income to pay for casual sex (Panos, 1992; World Bank, 1997). Nowadays, the AIDS epidemic is considered bi-modal in its effects, with peaks among the richer and better educated and the poorest segments of society (Cohen in Baylies, 2000a, p. 12). The poor now constitute the absolute majority of those living with HIV/AIDS (World Bank, 1997). Certain sectors, such as policing, justice, armed forces, health, education, mining, transport and construction, are particularly hard-hit (UNAIDS, 2001c).

The epidemic has mainly concentrated in urban areas: in 1992, between 25-33% of the population in some urban areas in the worst affected countries were HIV-positive, compared to less than five per cent in rural areas (Panos, 1992, p. 23). In the same year, AIDS had already become the leading cause of adult mortality in some African cities (Barnett and Blaikie, 1992). By 2001, the prevalence[7] of HIV/AIDS in some African cities has increased to 50% of adults (UNAIDS, 2000b). According to the World Bank (1997), the higher incidence[5] of HIV infection in urban areas can be explained by the fact that men tend to outnumber women in these areas, as they migrate to urban areas to seek employment, where they are more likely to engage in incidental sexual relationships. This view is supported by other sources (Collins and Rau, 2000; UNAIDS, 2001a). Because migration is often a circular process, both migrants and their partners back home are at increased risk of HIV infection (UNAIDS, 2001a).[8]

The preceding discussion has highlighted *who* is most vulnerable to HIV infection. Categories of vulnerable groups include people living in developing countries (especially in sub-Saharan Africa) and more specifically young adults and babies/infants, women, poor people, and people living in urban areas, especially migrants (and their partners back home).[9] Clearly, these are not isolated categories, but there is significant overlap between them. However, the discussion so far has not suggested *why* these social groups are more susceptible to HIV infection, nor has it looked at the *impact* of HIV/AIDS on individuals, households, communities and cities. Both issues will be further discussed in Chapter 2. Patterns of HIV-transmission, the scale and nature of the HIV/AIDS epidemic vary across the world (Carballo and Carael, 1988) and across and within developing countries (Whiteside and Sunter, 2000). According to UNAIDS (2001c, p. 9), the epidemic "actually comprises multiple epidemics, each adapting to local conditions". It is apparent, though, that HIV/AIDS is closely associated with inequalities at global, national and community level and that it follows the "fault lines" (Adler, 2000, p. 62) of society. It is equally evident that beneath the statistics presented above lie a human tragedy and a development crisis of global proportions. There is increasing recognition that HIV/AIDS impacts negatively on health and life expectancy, poverty and inequality, productivity and the urban economy, and the ability of the state to provide public services.[10] As Dr Peter Piot, Executive Director of UNAIDS said in a recent statement: "HIV must be placed at the center of development policy. The HIV epidemic has created a development crisis. It not only threatens to make the achievement of international development targets an impossibility, it is turning progress backwards by many decades" (UNAIDS, 2001b).

Conceptual Framing Of HIV/AIDS As A Health Issue

Without elaborating here on the causes of vulnerability to HIV/AIDS and the impacts of the epidemic, it is fair to say that neither causes nor impacts have been sufficiently understood in mainstream approaches to HIV/AIDS. From the outset, HIV/AIDS has been categorised as a medical and health concern (Collins and Rau, 2000; Panos, 1992). Thus, public debates have tended to focus on the need to develop a cure or

vaccine, on access to public health care and affordability of medical drugs, and, in the absence of a cure, on preventive measures. As a consequence, most research and public interventions have ignored the social, political and economic dimensions of the epidemic (Barnett and Whiteside, 2000). Over time, as the inability to find a cure led many to emphasise prevention as the only solution to curb the spread of HIV infection, academic and policy discourse on HIV/AIDS also included a focus on 'culture' and behavioural aspects (Mufune, 1999). These studies and interventions often emphasised individual responsibility to prevent infection. Without proper acknowledgement of the social and economic context in which individuals live and which can make them more or less vulnerable to infection, such an approach risks holding vulnerable groups responsible for their own infection and for further transmission (Collins and Rau, 2000; Farmer, 1996). This has led to stigmatisation and discrimination of certain social groups (Baylies, 2000b; Mufune, 1999; Osei-Hwedie and Osei-Hwedie, 1999), thereby exacerbating social divisions. This issue will be further discussed in Chapter 2.

HIV/AIDS: The Invisible Issue In Urban Development Planning

In as far as the epidemic is concentrated in urban areas and further strains economic prospects in rural areas, the nature and manifestation of HIV/AIDS will have particular relevance for urban development. In fact, HIV/AIDS is one of the most – if in some areas not the most – important urban development issues in developing countries, especially in sub-Saharan Africa. Yet, urban development planning is largely silent on the issue and there is a paucity of data on the impact of HIV/AIDS in urban areas (Barnett and Whiteside, 2000). We can identify various reasons for this omission. Firstly, as mentioned before, the conceptual framing of HIV/AIDS as a medical concern has precluded a broader theoretical perspective on the epidemic.

Secondly, the epidemic is associated with different types of 'invisibility'. The first type of invisibility relates to the relatively long time lapse between infection, illness and ultimately death. Thus, Barnett and Blaikie (1992) refer to AIDS as a "long wave event". This delayed impact has led some authors to speak of two epidemics: an HIV epidemic and an AIDS epidemic (Whiteside and Sunter, 2000). The second type of invisibility relates to the fact that initially the impact of HIV/AIDS-related illness and death is mainly felt at individual and household level; it takes time before its cumulative impact is felt by society as a whole (Baylies and Bujra, 2000a; Whiteside and Sunter, 2000). This invisibility allows one to ignore the gravity of the situation and misunderstand the nature and impact of HIV/AIDS.

Thirdly, HIV/AIDS is politically sensitive, as it touches on issues of sexuality, sexual practices, culture and gender relations (Baylies, 2000b; Osei-Hwedie and Osei-Hwedie, 1999). Some have argued that this sensitivity stems from the fact that HIV/AIDS is often associated with practices that are regarded as immoral or illegal, such as prostitution, infidelity or homosexuality (Osei-Hwedie and Osei-Hwedie, 1999). However, I agree with Baylies (2000a) that not all these sexual practices are necessarily considered socially unacceptable. The fact that in certain cultures and societies it is not considered immoral for men to have multiple partners clearly does not make it less politically sensitive, as addressing HIV/AIDS involves a process of social change.

Furthermore, HIV/AIDS is not only a thorny issue, it is also complex. HIV/AIDS is not merely an additional and isolated concern, but intersects with other urban development issues. Against this background of complexity, it is tempting to reduce the significance of HIV/AIDS to a sectoral issue in an attempt to make it more 'manageable' and expedient, or to ignore responsibility completely.

Finally, the HIV/AIDS epidemic is not occurring in a vacuum, but has inserted itself into a domain already characterised by great complexity. The complexity of urban development in developing countries stems from various factors, including pressures related to the global political economy, the existence of various stakeholders with often-conflicting needs and interests within the urban area, and the unpredictability of development trends and of the impacts of development interventions (Carley and Christie, 1992; Harvey, 2000). State capacity and resource constraints further compound the complex nature of urban development in developing countries. Moreover, urban development is a multi-dimensional process. Although separate dimensions (social/cultural, economic, political/institutional, spatial and environmental) can be identified, these dimensions are interconnected and interdependent.

The failure of urban development planning to incorporate HIV/AIDS clearly needs to be remedied. To assess how this could be done, it is useful to review to what

extent urban development planning, denoting both policy and practice, is capable of responding to the current complexities associated with urban development. It is necessary to have a yardstick to evaluate the effectiveness and inadequacies of both policy and practice. For this purpose, a working definition of urban development is needed. Although the literature presents no clear and uniform definition, this paper starts from the premise that urban development is a multi-facetted and multi-dimensional process towards the dual purpose of enhancing both people's quality of life and equality.[11] Furthermore, whereas different planning theories give different emphasis to planning process and desirable outcomes, sometimes stressing the one at the expense of the other (Fainstein, 2000), both outcome and process are important aspects of urban development.

Failures Of Urban Development Planning: Deficiencies In Theory And Practice

Despite notable strides in certain areas of development[12], there is a growing body of evidence in recent urban development planning literature that suggests that interventions labelled as 'development' have, in fact, exacerbated social and economic disparities, deepened poverty, and extended informality and fragmentation, especially in the context of structural adjustment and globalisation (see, inter alia, Balbo, 1993; Gleeson and Low, 2000; Sassen, 1994). Moreover, current interventions have often proved inadequate to respond to more recent problems, such as AIDS and environmental degradation. Inadequacies of mainstream urban development planning can have their origin either in its theoretical assumptions or in the 'interpretive leap' from theory to practice, or vice versa.

Theoretical And Ideological Deficiencies

At times, weaknesses in urban development planning stem from its theoretical and ideological underpinnings. For example, the traditional 'trickle down' economic view of development has proven to be flawed.[13] Instead, in most instances, economic growth approaches have led to uneven development and increasing social inequalities, rather than an equitable distribution of the benefits of economic growth (Potter and Lloyd-Evans, 1998; UNCHS, 2001). Thus, the anticipated "embourgeoisement"[14] (Beauregard, 1996, p. 216) has not transpired. This is not to say that economic growth is not significant. Rather, as Amis (1999) demonstrates in his comparison between East-Asia and Latin America, the *type* of economic growth is significant, as this will influence to what extent it concerns "growth with equity" (Ibid, p. 8). Furthermore, a purely economic definition of development ignores the fact that well-being – and its antithesis poverty – cannot be measured in economic terms alone, but also has social and political dimensions (UNDP, 1997; Wratten, 1995).[15] Another assumption that has been increasingly challenged relates to the conceptualisation of a homogeneous public interest, thus ignoring social diversity and social relations (Beauregard, 1996). In failing to recognise the existence of "multiple publics" (Sandercock, 1998, p. 30), development interventions have further entrenched the status quo.

Deficiencies In Implementation

At other times, inadequacies in the practice of urban development planning are not caused by inappropriate theory or incorrect assumptions, but because theoretical perspectives prove difficult to translate into tangible, effective strategies for implementation. Moreover, strategy development and implementation are processes of interpretation, contestation, negotiation and experimentation. As acts of social interaction, they are mediated by power relations.

Inadequacies Of Urban Development Planning

The following section will explore inadequacies of urban development planning in relation to the economic, social/cultural, environmental, spatial and political/institutional sphere. Although each sphere will be discussed separately, these clearly constitute inter-related, rather than isolated, dimensions of urban development. Although reference is made to developing countries in general, this term clearly masks a great deal of variety between and within these countries.

Economic Sphere

Recent changes in the global economic system have allowed for a greater role for cities in promoting their economies (Healey, 1996). Many cities have adopted a marketing approach to gain comparative advantage within the global economy and have restructured the urban economy to appeal to global business, based on the assumption that economic globalisation is beneficial and that its benefits will eventually trickle down to all parts of the world (UNCHS, 2001). However, global opportunities (which are not equally

available to all urban areas in the first place) do not necessarily present the best possibilities for locally appropriate and equitable economic development (Gleeson and Low, 2000; UNCHS, 2001; Vidler, 1999). This is evidenced by the fact that global economic restructuring has led to a decline of certain economic sectors (like manufacturing), increasing unemployment, increasing informal sector activities, and the creation of less stable and low income jobs in the services sector (Castells and Portes, 1989; Harris, 1997; Sassen, 1994). Cities, as primary sites of economic activities most threatened by global economic changes, have been disproportionately affected (Batley, 1997). As a consequence, urban poverty has increased and continues to rise (UNCHS, 1996; Vidler, 1999).

At the same time, these negative trends have been accompanied by an increase in highly specialised and highly paid positions in other sectors of the urban economy (Sassen, 1991). The result is the concentration of wealth in the hands of a few and greater socio-economic disparities (Ibid). According to UNCHS (2001, p. 32), in the last 30 years the poorest 20% of the world's population has seen its share of global income decline from 2.3% to 1.4%, whereas the share of the richest 20% has increased from 70% to 85%.[16] These polarising tendencies are also starkly evident in cities in developing countries (Gleeson and Low, 2000).

Whereas the dominant paradigm holds that economic growth is necessary for poverty reduction, thereby encouraging cities to become globally competitive, it has been demonstrated that decreasing income inequalities may be more effective. In countries where income is fairly evenly distributed, an economic growth rate of 10% reduced the percentage of people living on US$1 a day by 9%, whereas in countries with a more unequal distribution of income this figure dropped by only 3% (UNCHS, 2001, p. 15). With respect to urban areas, Amis (1999) argues that the type of economic growth determines whether urban poverty and inequality will increase or decrease. Moreover, because poverty and inequality are not only about income, disparities in service provision and infrastructure development also need to be addressed (Ibid). This takes us to the next dimension of development.

Social And Cultural Sphere

A growing body of urban literature identifies cities as places of diversity and strategic sites of social change (UNCHS, 2001). Theoretical perspectives on urban development increasingly reflect a social diversity perspective. Yet, in practice there is little evidence that urban development planning in developing countries is effective in responding to the existence of disparate needs, interests and the differential extent to which people from diverse social backgrounds can exert, in the words of Sen (1999), "individual agency" (see Polèse, 2000; Sandercock, 1998). Instead, social exclusion and polarisation between and within urban areas have exacerbated, with race, ethnicity, class and gender creating intersecting patterns of differentiation (UNCHS, 2001). Health status and access to health care are important indicators of social inequalities (Stephens, 1996). According to Richard Wilkinson (quoted in Collins and Rau, 2000, p. 5), "it is now clear that the scale of income differences in a society is one of the most powerful determinants of health standards in different countries, and that it influences health through its impact on social cohesion". Similarly, Gleeson and Low (2000) argue that increasing inequality in access to basic urban services is resulting in political disenfranchisement.

Moreover, urban development planning in developing countries has not been able to keep up with demographic changes, especially the high growth rate caused by natural population growth and migration (Armstrong and McGee, 1985; Balbo, 1993) and the increased level of cultural diversity[17] (Appaduria, 1990; Sandercock, 1998). In developing countries, increasing cultural diversity in urban areas is not necessarily associated with foreign migrants (Stren and Polèse, 2000), although foreign migrant labourers and refugees can make up a significant amount of new entrants into urban areas (UNCHS, 1996). In these cases, new arrivals in urban areas tend to be minority populations without citizenship rights (UNCHS, 2001). Increasing cultural diversity of cities has further challenged assumptions of homogeneity and social cohesion as it has often resulted in cultural separation and alienation (Bianchini, 1993). Although it is not the only, or necessarily the most important, aspect of cultural identity, cultural identities often have a material and political basis, which is reflected in levels of inequality and social exclusion (Bianchini, 1993; World Commission on Culture and Development, 1996). Responses to cultural diversity in the city have tended to ignore this (Bianchini, 1993). But, as Fainstein (1999, p. 259) argues: "An ethos of diversity cannot be developed separately from an understanding of the economic bases of

inequality". Furthermore, urban development planning has failed to take into account the scale, nature and impact of the AIDS epidemic (Barnett, 1999; Collins and Rau, 2000). As a consequence, urban development planning has not been able to keep up with demands that have both increased and become qualitatively different.

Environmental Sphere

Recently, a growing body of literature addresses the role of city governments to promote environmental sustainability (Atkinson and Dávila, 1999). In theory, there is increasing recognition of the contribution of local industries and of the consumption patterns of middle class urban residents to environmental degradation, both within the city borders and beyond (Satterthwaite, 1999). Yet in practice, there has been a noted failure of relevant authorities to provide a healthy and pleasant living and working urban environment for all inhabitants, whilst safeguarding this potential for future generations (Ibid). Not only have efforts to curb environmental degradation been weak, but such efforts have also been inadequate in preventing and responding to environmental hazards[18], which disproportionately affect low-income settlements and further aggravate impoverishment (Ibid). As Satterthwaite (1999, p. 25) states: "It may be misleading to refer to many of the most pressing environmental problems as 'environmental' since they arise not from some particular shortage of an environmental resource … but from economic or political factors which prevent poorer groups from obtaining them or from organizing to demand them". A key challenge for urban development planning is not only to respond to both 'green' and 'brown' environmental concerns, but to recognise the interrelationship between these sets of concerns to avoid the transfer of environmental burdens within cities, beyond cities, globally and into the future (Haughton, 1999; McGranahan, Songsore and Kjellén, 1999). This requires a recognition of the link between consumption, poverty, inequality and environmental degradation (Gleeson and Low, 2000).

Spatial Sphere

Socio-economic inequalities and polarisation are reflected in urban physical space (Balbo, 1993; Harvey, 1996). This results in a "geography of inequality" (Satterthwaite, 1999, p. 16). Spatial fragmentation is evident in the existence of different settlement patterns with differential levels of services and infrastructure and a variety of tenure conditions (Balbo, 1993). Class is not the only factor in this regard. As Bianchini (1993) argues, the separation of cultural groups – often associated with economic inequalities – tends to have a spatial dimension. Polarisation and economic differentiation as a result of economic globalisation have entrenched existing patterns of segregation of people and land uses by inducing 'the quartering of urban space' (UNCHS, 2001, p. 32). The UNCHS (2001) identifies five types of residential cities, each with a parallel city of business and work, within municipal boundaries.[19] Each of these 'cities' has its own dynamics of development. Walls, roads, highways, open spaces, rivers or other demarcations indicate the boundaries between these different neighbourhoods (Ibid). Whereas the UNCHS (2001) notes with concern that there is a trend towards solidifying these boundaries, it also notes that there are interventions aimed at upgrading poorer areas. However, the danger is that upgrading may lead to gentrification, resulting in the displacement of existing and poorer residents, with disproportionate public investment in certain areas to project a positive image of the city (Ibid).

Political And Institutional Sphere

The increasingly prominent contribution of cities to the national and global political economy has lead to a greater valuation of the role of municipal governments. Dominant theoretical perspectives on urban governance, decentralisation and local democratisation tend to be based on various assumptions that can be contested.

The first assumption relates to the level of power, authority, political will, resources and capacity of municipal governments in developing countries. Without adequate recognition of the structural context in which cities are located and the institutional factors that hinder the capacity of municipal governments, there is a danger that promoting a greater role for municipal governments may simply lead to a shift of the burden of responsibility from higher levels of government.[20] Yet, in many urban areas in developing countries, a clear locus of management authority is often lacking (Devas and Rakodi, 1993). Moreover, they are characterised by weak administrative capacity (Turner, 1992) and weak, unsustained or inconsistent political direction (Batley, 1997).

In recognising the capacity constraints of local government in the face of ever-increasing urban complexity, some argue for multi-stakeholder involvement in urban development (Turner, 1992; UNCHS, 1996).

The assumption here is that such involvement will relieve the burden of responsibilities on local government. Yet, the need to coordinate multiple stakeholder involvement adds to the complexity of urban development, thus further challenging the already limited institutional capacity of municipal governments (Carley and Christie, 1992).

Often, the promotion of multi-stakeholder involvement has entailed a shift towards market mechanisms, either through the notion of public-private-partnerships or through privatisation of public sector services (Batley, 1997; UNCHS, 2001). The assumption underpinning this approach is that market forces will deliver public services, and that they will do so better, faster and more cost-effective than the public sector. Yet, this view ignores the fact that the private sector's main interest lies in profit making and has a "more ambiguous position in regard to equity – both within contemporary society and inter-generationally" (UNCHS, 1996, p. 430). As Dávila and Atkinson (1999) caution, reliance on market forces tends to have negative implications for social and environmental objectives. Moreover, the public sector tends to serve as a 'backstopper', which allows the private sector to renege on contractual agreements or opt out of unprofitable ventures (UNESCO, 1998).

There is also a political rationale for involving multiple stakeholders in the process of urban development. On the one hand, there is a moral imperative for the private sector to contribute to social and environmental objectives (Elkington, 1997). On the other hand, representative democracy has inherent limitations (McCarney, 1996). Thus, a case is made for participative democracy and inclusive decision-making as a means to ensure social inclusion, a better satisfaction of needs and political empowerment. However, despite notable successes[21], there are indications that the ideal of "collaborative planning" (Healey, 1997) is seriously hampered by disparate interests, power dynamics, unrealistic expectations regarding community participation and limited institutional capacity (Fainstein, 2000; Patel, 2000). This challenges the assumption that 'the public' has a uniform interest and that public participation by definition will lead to a better development outcome.

The Need For A New Normative Paradigm

From the preceding discussion we can conclude that one of the main failures of mainstream urban development planning is its inability to address growing inequality in a context characterised by increasing complexity and rapid change. A new, or more explicit, normative paradigm is needed that will allow for a reassessment and revision of urban development planning. Utopian thinking serves a useful and necessary purpose of imagining what a city should and could look like. In many instances, such a vision informing urban development planning may be implicit (Friedmann, 2000). The benefit of explicitly articulating a guiding image of the type of cities we want to see is that it serves both an evaluative and a normative purpose (Ibid). It is *normative*, in that it guides decision-making and interventions in accordance with the principles and values espoused in the vision. It is *evaluative*, in that it provides a framework to assess the past, the present and the impact of development interventions. Clearly, such a framework needs to be sufficiently rooted in practice to do justice to the complexity of urban development, whilst at the same time transcending the mundaneness of everyday life. In other words, it has to hold the dialectic between universality and contextuality. Another advantage of explicating a vision of the city is that it can elevate decision-making beyond narrow self-interest (Fainstein, 1999). This could be achieved by including an element of altruism and embracing a long-term perspective that takes the interests of future generations and the need for ecological integrity into account. However, as Friedmann (2000) cautions, we cannot assert a conclusive ideal-type of the city, as the image itself is dependent on local conditions and is developed and enhanced through public discourse. The remainder of this chapter will explore whether images of the 'good city' or 'just city' provide a useful normative paradigm. These models differ from mainstream urban development planning in that they explicate clear guiding principles regarding a particular desirable outcome and the process of achieving that outcome. In this way, urban development planning becomes an explicitly political act, rather than merely a (presumed) technical exercise.

The Good City

Historically, utopian planning has a strong focus on urban design, viewing the 'good' city as something that could be engineered by proposing physical solutions to social problems (Mooney, Pile and Brook, 1999). Friedmann (2000) has adapted the terminology of utopian planning to articulate his own ideas about the good city, which has more to do with governance than with urban design. In his view, the good city is

underpinned by ”human flourishing”, which refers to the right of every human being to “the full development of their innate intellectual, physical and spiritual potentials in the context of wider communities” (Ibid, p. 466), and by “multipli/city” (Ibid, p. 467), which refers to an autonomous and vibrant civil life. These two elements can only be realised within the framework of a liberal democracy and if there is a solid material base, which has four pillars: adequate housing and basic services; affordable healthcare; adequately remunerated work; and adequate social provision (Ibid, p. 468). In Friedmann’s (2000) view, the development process cannot be separated from development outcomes. Although he acknowledges that democratic pluralism does not always serve dominant interests and that it is therefore important to have clear objectives, the centrality of “an autonomous, self-organizing civil society” (Ibid, p. 471) in his argument implies that those objectives can only be collectively defined by “the people” (Ibid, p. 465). Such an optimistic belief in the fact that rational discourse will automatically lead to progressive and transformative outcomes has been widely criticised (Fainstein, 2000; Patel, 2000; Sandercock, 2000; Yiftachel and Huxley, 2000) for ignoring the “messy political and economic realities of urban … development” (Yiftachel and Huxley, 2000, p. 908).

In his discussion of the good city, Friedmann pays little attention to the question of how issues of power restrict the potential of certain people to make demands on the city, although in his earlier work he discusses this more explicitly (see Friedmann, 1992). Whilst recognising the importance of a solid material base as a condition for people to act in the political sphere, he does not address the fact that there are other dynamics of inequality beyond basic needs that restrict the equal and effective participation of different social groups. Social and cultural biases entrenched in institutional arrangements also create significant barriers, as theory on gender planning has shown.

Moreover, although Friedmann states that there is no single, conclusive image of the city because there are many different starting conditions in cities throughout the world, he proceeds to present an ideal-type without specifying for which context this image would be appropriate. One is left with the question whether he has articulated his vision of a liberal democracy combined with a welfare state for a Western city – in which case his description largely corresponds with the current reality in these cities, thus raising the question to what extent he is in fact highlighting the failure of the vision that he seeks to promote. Alternatively, he could be suggesting that the dominant model of Western cities serves as a guiding image for cities in developing countries – in which case he is undermining his own argument that there cannot be a single image of a good city.

The Just City

An alternative model to Friedmann’s ‘good city’ is the ‘just city’. Fainstein (2000) distinguishes between two categories of just-city theorists: radical democrats, who argue that social change will only be achieved by those who have been excluded from power, and political economists, who view social and spatial inequality as the inevitable outcome of capitalism and propose a model of spatial relations based on equity. She locates herself within the political economy tradition, although she challenges the narrow class analysis that has dominated political economy theory. Moreover, Fainstein acknowledges that the needs of the middle class and the aspirations of the working class to become middle class cannot simply be discarded. Thus, any notion of what constitutes the just city has to combine equity, achieved through redistribution, with economic growth to ensure an improved quality of life for all urban citizens (Ibid).

In her discussion of the just city, Susan Fainstein (2000) also engages with the dynamic relationship between process and outcome. She argues that the just city model values both equity of outcomes and the participation of relatively powerless groups in decision-making. However, Fainstein (2000) avoids a simplistic understanding of pluralist democratic processes by arguing that inclusive processes may not lead to just outcomes. This realisation leads her to argue that it is important to “erect a pantheon of values” (Fainstein, 1999, p. 251). Fainstein articulates four principles of social justice: material equality; social diversity; democracy and environmental sustainability (Ibid). Although she asserts that specific historical contexts will determine which one should be prioritised and what strategies should be pursued to realise these values, Fainstein seems to regard material equality as the primary principle. Fainstein argues that the four principles are “beneficent yet discordant” (Ibid, p. 252), which is even more so when they have to be reconciled with more traditional or ‘conservative’ values such as order, efficiency and economic growth (Ibid). Fainstein (2000, p. 471) argues that the just city model can only be realised in a context characterised by

democratic procedure, relative material equality, a culture of tolerance and a commitment to equity.

Towards A Just City In A Developing Context

It is important to bear in mind that both Fainstein and Friedmann discuss their 'utopias' mainly in relation to the urban context in Western countries. The conditions for the 'good city' articulated by Friedmann (2000) correlate with the existence of a welfare state, whereas Fainstein's (2000) 'just city' can only come about in the context of a liberal democracy, albeit one based on solidarity rather than individualism. However, that does not mean that these models do not have value in the context of developing countries, where many cities approximate "dystopias" (Friedmann, 2000, p. 162).

The notion of a just city holds particular appeal, because of its explicit emphasis on social justice. Fainstein's (2000) view correlates with the perspectives of Harvey (1988), Smith (1994) and Young (1990) that social justice is not only concerned with outcomes and the fair distribution of material goods and services, but also has a relational dimension concerning the process that will lead to desired outcomes. However, Fainstein's words of caution regarding the limitations of pluralist democracy require careful attention. In my view, commitment to certain principles and values need to define (and occasionally confine) the parameters of the participative process. Nevertheless, the choice for and interpretation of these values and principles are themselves part of an ongoing dialogue in a particular context – a dialogue that is clearly not devoid of power dynamics.

In relation to the inter-related dimensions of urban development discussed previously, I propose a refinement of Fainstein's (1999) principles of social justice to articulate the following principles for the just city:

equitable standard of living, which refers to the provision of services, infrastructure and income-generating opportunities based on fairness;[22] *social inclusion and respect for cultural identity*, both of which are underpinned by a recognition of social diversity;[23]

democracy, which is interpreted as a combination of representative democracy with inclusive participative democracy;[24]

institutional effectiveness and efficiency, which refers to the institutional capacity to achieve certain objectives within the shortest possible time and with minimal resource implications;

economic growth with equity, which qualifies the type of growth and implies redistributive mechanisms to ensure that the benefits of economic growth are fairly distributed (after Amis, 1999);

spatial integration, which is valued in as much as it counters inequalities and cultural alienation or segregation;

ecological integrity, which implies remaining within planetary biophysical carrying capacity (Robinson and Tinker, 1998, p. 22) and a non-transference of burdens and responsibilities beyond city boundaries or into the future (after Haughton, 1999).[25]

Clearly, these principles are interdependent – and potentially contradictory. Therefore, urban development planning needs to promote consistency between these various principles as much as possible. Such consistency is probably easier to find in theory, when abstracted from reality, than in practice. Furthermore, because cities do not exist in a socio-economic and political vacuum, there is a question to what extent the just city can be achieved in an unjust world. It is beyond the scope of this paper to address this issue.

Conclusion

The scale and features of HIV/AIDS suggest that HIV/AIDS, with its tendency to follow the fault lines of society and exacerbate social polarisation, will undermine development prospects. As such, it may pose one of the most serious urban development challenges in developing countries, particularly in sub-Saharan Africa. Yet, urban development planning has been slow to recognise this. Because HIV/AIDS intersects with other development concerns and dynamics, it cannot be seen in isolation of the broader complexities of urban development. Unfortunately, mainstream urban development planning has not been very successful in responding to the complexity of urban development challenges, in particular to growing inequality, in a context of rapid change – even without considering HIV/AIDS. In response to this inadequacy in dealing with inequality, this chapter concluded by proposing a set of principles that can form the basis for a just city in developing countries.

Although utopian thinking is important, it does not automatically result in the realisation of the professed ideals and principles. This is because the leap from theory to practice constitutes a process of interpretation, contestation and experimentation, which is itself fraught with power dynamics. The just city principles should be seen to be a starting point rather

than the end of urban development planning. The next chapter will explore the possibility of realising the just city and the relevance of these principles in the context of the HIV/AIDS epidemic.

2. HIV/AIDS AS A CHALLENGE TO THE JUST CITY

"The layers of inequality and of inequitable power relations which set the context of the epidemic are paralleled by layers of differentially circumscribed agency – at global, national and community levels, as well as at the level of the couple and the individual. From the perspective of social justice and human rights, these in turn reply layers of responsibility towards fellow human beings, citizens, neighbours, partners, oneself and one's children. What is crucial, not just for explaining the course of the epidemic but also for crafting strategies of intervention, is recognition of the structural connections between these layers of inequality, agency and responsibility" (Baylies, 2000b, p. 487).

Introduction

The previous chapter has suggested that HIV/AIDS is not a marginal concern, nor merely a health issue. Instead, it is intertwined with other development concerns and "profoundly grounded in social behaviour and underwritten by social relations of inequality" (Baylies and Bujra, 2000a, p. 483). This chapter will focus explicitly on the interplay between HIV/AIDS and inequality. First, inequality is identified as a key factor in vulnerability to HIV infection. Furthermore, the devastating impacts of HIV/AIDS are likely to exacerbate inequality and add new dimensions of exclusion and discrimination to social relations. This is demonstrated by looking at the impacts of HIV/AIDS on the dimensions of urban development, with emphasis on the differential impacts on social groups. After exploring the link between HIV/AIDS and inequality, I conclude that the HIV/AIDS epidemic poses a threat to the realisation of the just city. Whereas the promotion of the just city can help to create the conditions that enable a more effective response to HIV/AIDS in the urban context, this does not automatically assure that HIV/AIDS will sufficiently be addressed. Instead, the just city principles need to be interpreted in such a way that takes account of the multiple and cumulative impacts of HIV/AIDS. The final section of this chapter suggests how the just city principles could be interpreted to include a better understanding of HIV/AIDS.

HIV/AIDS As A Manifestation Of Inequality

HIV/AIDS is closely associated with inequalities at global, national and community level. As Table 1.1 shows, the epidemic is concentrated in developing countries, with sub-Saharan Africa disproportionately affected. The high spread of HIV in developing countries is indicative of global inequalities (Baylies and Bujra, 2000a; Collins and Rau, 2000). According to UNAIDS (2001c, p. 4), poverty, poor education and health systems, limited resources for prevention and care, and displacement caused by economic hardship and violence fuel the spread of the epidemic in developing countries. The disproportionately high level of poverty in sub-Saharan Africa is considered a key factor in the extremely high incidence of HIV/AIDS in the region.[26] Structural adjustment policies and international debt have compromised the ability of governments in developing countries, in particular in Africa, to provide a minimum standard of public services to all citizens (Baylies, 2000b; Collins and Rau, 2000).

Global inequalities are further evidenced in the dominant influence of market forces in the development of global responses to the AIDS epidemic. Driven by principles such as cost-effectiveness and profitability, pharmaceutical transnational corporations have tended to focus on industrialised countries, thereby ignoring the subtypes of HIV in Africa (Baylies, 2000a). Moreover, the cost of patented drugs is often pitched beyond the reach of governments, let alone the majority of people, in developing countries (Oxfam, 2001; VSO, 2000).[27] As UNDP (2001, p. 9) notes, "Access to affordable treatment and adequate health care has become one of the most important differentiating factors between HIV related survival in rich and poor countries and communities". It is beyond the scope of this paper to explore the nature of these global inequalities in further detail.[28]

At national and local level, the uneven distribution of HIV/AIDS is closely associated with social divisions based on factors such as age, class, gender, race[29] and ethnicity. Collectively, these factors create "interlocking structures of inequality" (Baylies, 2000b, p. 492), which enhance vulnerability to HIV infection and the impacts of AIDS. It needs to be noted, however, that factors such as race or ethnicity per se are not sufficient in explaining higher prevalence. Rather, it is the socio-economic status of ethnic groups that makes them more or less vulnerable to

HIV/AIDS (Simmons, Farmer and Schoepf, 1996). This is not to deny that cultural practices and norms can contribute to the spread of HIV/AIDS.[30] The question is why these social groups tend to be more vulnerable to HIV infection.

Given that *young adults* constitute the majority of sexually active people, it is not surprising that HIV/AIDS disproportionately affects this category. However, sociological factors also need to be taken into account. This age group constitutes the majority of migrants in search of economic security (Collins and Rau, 2000). Chapter 1 suggested that migration and mobility are considered risk factors that increase vulnerability to HIV/AIDS. Moreover, in Africa processes of social change have led to later marriage, a loss of meaning of traditional cultural forms of sex education, and changing patterns of sexual behaviour – all of which may enhance vulnerability to HIV infection (Baylies, 2000a). Furthermore, experiences of social disillusionment amongst the youth and low expectations of tangible changes in the near future may lead young adults to engage in risk behaviour (Collins and Rau, 2000).

Similarly, vulnerability of *the poor* to HIV stems largely from the fact that poor people are more likely to adopt strategies that are conducive to the spread of HIV, such as migration and engagement in (commercial and non-commercial) sex work (Collins and Rau, 2000; UNAIDS, 2001c), and least likely to be able to access or afford measures that allow them to practise safe sex. As Baylies (2000a) suggests, risk behaviour by people who are not poor is largely a matter of power and choice, whereas poverty forces the poor into behaviour that puts them at risk of infection. Moreover, appropriate health care and education that could reduce the risk of HIV infection is often not equally available or affordable to poor people.[31]

Whilst there are biological factors that make *women* more vulnerable to HIV infection than men, gender inequality is clearly a significant factor (Baylies, 2000a; Baylies and Bujra, 2000a; Simmons, Farmer and Schoepf, 1996). Women's inferior social status makes them extremely vulnerable to HIV infecton, as they are least able to negotiate safe sex or to prevent sexual violence.[32] Cultural values regarding masculinity based on sexual conquests (Baylies, 2000a) lead young men to downplay the threat of HIV/AIDS and engage in risk behaviour. Also, poverty and gender inequality are intricately intertwined, with women constituting the majority of the poor (World Bank, 1997). As Baylies (2000b) argues, a fundamental transformation of gender relations is required to stem the AIDS epidemic. This view is supported by the World Bank (1997, p. 29) when it suggests that a reduction in the male – female literacy gap of 20% could reduce HIV infection rates in urban areas by four percent.

Baylies (2000a) contends that marriage can constitute a particular context of vulnerability to HIV/AIDS for women. According to research in Uganda, for example, HIV-positive women between 13-19 years were twice as likely to be married as those who were not infected (Ibid, p. 11). This vulnerability stems from the fact that men tend to have more partners in earlier years of marriage, especially during their wife's pregnancy or in the first port-partum months, and that the desire to have children makes protection against HIV impossible (Ibid). Within the context of marriage, condom use is often non-negotiable (CIIR, 1999). If marriage enhances women's vulnerability HIV/AIDS infection, divorce and widowhood do so even more. Findings in some African countries show that HIV prevalence rates are disproportionately high amongst divorced and widowed women (Baylies, 2000a). One explanation is that disease progresses more rapidly with age and because women tend to get infected at a younger age then men, they often outlive their husbands (Ibid, p. 12). Other reasons are that men are more likely to divorce HIV-positive partners and remarry, and that economic impoverishment faced by divorced and widowed women may lead them to engage in sexual activities, thus exposing them to greater risk of HIV infection (Ibid).

The spatial manifestation of HIV/AIDS is associated with the concentration of marginalised social groups and with movement patterns.[33] Many of the worst affected countries show a clear urban-rural differential in respect of HIV/AIDS, with a higher prevalence rate in urban areas. In some countries, the urban-rural distinction is much less clear. For example, in Tanzania (Bujra and Baylies, 2000) and in South Africa (UNDP-SA, 1998; Department of Health, 2000), HIV/AIDS is concentrated in certain districts or provinces where both urban and rural areas show a high HIV prevalence. The epidemic moves along main transport and trading routes (Simmons, Farmer and Schoepf, 1996), with transit stops showing disproportionately higher levels of HIV concentration (Bujra and Baylies, 2000). I was unable to find comparative research on spatial patterns of HIV/AIDS within urban areas. Yet, its close interrelation with poverty and

inequality suggests that low-income settlements with inadequate services and infrastructure are likely to have higher HIV prevalence rates.

Independently, socio-economic position, age, gender and marital status enhance vulnerability to HIV/AIDS.[34] Collectively, these factors interlock to create "a complex web of vulnerability" (Baylies, 2000a, p. 13). Given that HIV transmission in sub-Saharan Africa occurs mainly through heterosexual sex, gender – and its intersection with other factors – clearly is a core factor.

HIV/AIDS And Inequality: A Bi-Directional Relationship

Although HIV/AIDS does not spare the elite (Hope, 1999), the preceding discussion has sought to demonstrate that certain social groups[35], such as young adults, migrants, women and poor people are disproportionately vulnerable to HIV infection. However, Baylies (2000b) rightfully cautions against equating risk groups with socially marginal groups as risky behaviour is often undertaken by men, who are neither marginal nor is their behaviour necessarily atypical. Most of the groups vulnerable to HIV/AIDS already tend to have a marginalised and disadvantaged status in society, and the stigma and blame attached to HIV/AIDS tends to further entrench this (Frankenberg, 1988). For example, recent research in Africa shows that young people are blamed for the AIDS epidemic (Baylies and Bujra, 2000b). Likewise, women have characteristically been viewed as responsible for the spread of HIV/AIDS (Baylies, 2000a; Farmer, 1996; Frankenberg, 1988).[36]

Thus, HIV/AIDS does not only manifest itself along these dividing lines, it also has the capacity to reinforce and exacerbate vulnerability and inequality. Collins and Rau (2000) have argued this point in relation to poverty and HIV. They see a "bi-directional relationship" between poverty and HIV: on the one hand, poverty is a factor in HIV transmission and exacerbates the impact of HIV/AIDS, whilst on the other hand HIV/AIDS can intensify poverty in poor households and push non-poor households into impoverishment (Ibid, p. 6). This analysis can be broadened to include all forms of social division and inequality. For example, gender inequality is not only a factor in vulnerability to HIV/AIDS, it is likely to be reinforced as the burden of care on women increases. This point will be elaborated on below when we look at the devastating impacts of the epidemic.

Impacts Of HIV/AIDS On Urban Development

Because the HIV/AIDS epidemic is still evolving, not all its devastating impacts have been measured. Instead, projections are used to suggest its impacts (Whiteside and Sunter, 2000). In the absence of reliable data on HIV/AIDS in urban areas, the implications for urban development have to be inferred from national and global statistics. It is clear, though, that although HIV/AIDS poses a severe challenge to urban development, it does not affect everyone in the same way – which is in itself a challenge to urban development planning.

Demographic Impacts

Whereas the full scale of the impact of the AIDS epidemic still needs to be felt, it is now widely accepted that the demographic impacts are devastating. These include an increase in adult and child mortality rates[37], leading to reduction of life expectancy at birth (Panos, 1992; UNGASS, 2001b) (See Box 2.1). As mentioned before, AIDS has already become the leading cause of adult mortality in some African cities. Poor people with HIV tend to develop AIDS much faster, because their immune system tends to be weaker and they are less able to afford medication or change their nutritional intake in an attempt to slow down the debilitating effects of the virus (Collins and Rau, 2000; Hope, 1999). Likewise, gender disparities also impact on the course of disease, with HIV-positive women having shorter survival times than HIV-positive men (Simmons, Farmer and Schoepf, 1996, p. 51). It is less clear how HIV/AIDS will affect fertility[38] and how it will impact on migration and urbanisation[39].

Box 2.1 Demographic impacts of HIV/AIDS

In sub-Saharan Africa life expectancy at birth between 1995-2000 is 6.5 years less than it would have been in the absence of AIDS (UNGASS, 2001b). By 2010, there will be 71 million fewer people in the region because of AIDS (UNDP, 2001). It is expected that in most countries HIV/AIDS will slow population growth rates, with a negative growth rate for countries like Botswana, Zimbabwe and South Africa from as soon as 2003 (Ibid).

Social Impacts
The social impacts of HIV/AIDS are manifold and occur at the level of the individual, household, community, city and society at large. These include loss of household income and vulnerability to impoverishment, entrenching power imbalances, orphanhood, pressures on the health system and the educational system, and changes in cultural practices. Each of these is briefly discussed here.

Impoverishment And Inequality
HIV/AIDS-related illness or death results in a reduction of household income and a diversion of household funds from nutrition and schooling to health care (Panos, 1992; World Bank, 1997) (See Box 2.2). Loss of family assets and lack of legal protection are likely to make women particularly vulnerable to impoverishment after the AIDS-related death of a husband or male relative (Panos, 1992; UNDP, 2001). In general, impoverishment will deepen and the gap between rich and poor will widen (UDNP, 2001).

Inequalities in relation to health and educational services have a particularly significant impact on the spread of HIV/AIDS (Panos, 1992). Disparities in access to health care and affordable treatment force poor households to somehow cope with HIV/AIDS-related illnesses, thus significantly reducing survival (UNDP, 2001). Moreover, these disparities are exacerbated as insured populations access more expensive tertiary health services (Ibid). Likewise, those who are better off and have a better education tend to have more access to information regarding the risks of HIV/AIDS and are more likely to possess the means (financial and otherwise) to act on the information (Baylies, 2000a).

There are other ways in which HIV/AIDS tends to reinforce social divisions and inequality. For example, women and children are expected to carry the burden of care for those who are sick and dying (Farmer, 1996; UNGASS, 2001b). Increasingly, children will take on 'adult' roles, such as contributing to household income and performing household tasks (Panos, 1992). It is feared that this will further complicate the problem of child labour (UNGASS, 2001b). Likewise, there will be pressure on elderly people to, once again, assume these responsibilities (UNAIDS, 2001c).

Orphanhood[40]
In sub-Saharan Africa, more than 12 million children have been orphaned because of AIDS (Nevill, 2001). This figure is expected to rise to over 40 million within the next decade (UNGASS, 2001b). Orphans are likely to suffer an interrupted or abruptly ended education, malnourishment and social exclusion (Panos, 1992; Whiteside and Sunter, 2000).[41] Orphanhood is associated with child labour and the phenomenon of child-headed households. It has also been suggested that the absence of adult role models will lead to an increase in crime, thus resulting in social instability (UNGASS, 2001b).

Pressures on health system
The impacts of HIV/AIDS on health and health care have been most widely recognised. These include an increased cost of public health care, increased competition with other diseases for scarce resources and overcrowding of hospitals (UNDP, 2001; World Bank, 1997). Pressures on the health system imply that hospital staff experience increasing levels of stress, especially in a context where they are unable to cure or treat people (Panos, 1992). In Africa, the HIV/AIDS epidemic is considered a key factor in the increase of tuberculosis cases by 10% per year amongst both HIV-positive and HIV-negative people (UNAIDS/WHO, 2001), thus adding further stress to the health system. Over the next decade, the incidence of tuberculosis is likely to double (Ibid).

Box 2.2 HIV/AIDS and household income
In Côte d'Ivoire urban households that have lost at least one family member to AIDS have seen their incomes drop by 52-67%, while their health expenditures soared four-fold (UNAIDS, 2001c, p. 9). To cope, they have to cut their food consumption by up to 41% (Ibid). Similar evidence has been found in Zambia, where in two thirds of the cases the death of the father resulted in a drop in monthly disposable income by more than 80 percent (UNDP, 2001, p. 10).

Collapse Of Educational Systems
AIDS impacts on both the availability and use of schooling (UNDP, 2001). On the one hand, school enrolment in various developing countries has dropped. Loss of household income often means that households can no longer afford to send children to school. Also,

children may drop out of school in order to care for or work instead of sick parents (Ibid). Children orphaned by AIDS are most likely to drop out of school (Ibid). On the other hand, high levels of teacher mortality and ill health due to HIV/AIDS compromise the quality and availability of education (Ibid). A collapse of educational systems ultimately undermines national development, income growth and labour productivity (Ibid).

Changing Cultural Practices
There is evidence in some areas in Africa that funeral practices are changing to cope with the high costs and loss of productive time associated with frequent funerals (Panos, 1992, p. 51). To what extent cultural practices, such as levirate, will change because of HIV/AIDS is as yet unclear (Carballo and Carael, 1988). Some have suggested that although the custom of widow inheritance persists in some areas, increasingly widows remain unmarried (Baylies, 2000a, p. 12).

Economic Impacts
HIV/AIDS is also expected to impact negatively on economic productivity, not only through illness and death, but also because healthy people are forced to take time off to look after the sick and attend funerals (Panos, 1992).[42] The epidemic is reducing labour supply and undermining the skills base (UNGASS, 2001b).[43] It could change the labour profile and increase informal sector activities (Panos, 1992). With productivity and competitiveness compromised, new investors will be discouraged (Ibid).

Political And Institutional Implications
The cumulative impact of HIV/AIDS, and its potential to undermine efforts to promote (urban) development, adds further stress to political and administrative systems responsible for urban development. With the public sector itself badly affected by the loss of skilled and experienced human resources, the ability of governments to deliver basic services will be severely compromised. The result is a situation of "double jeopardy" (UNGASS, 2001b, p.3), where there will be less capacity and resources to meet increased demands. Ultimately, HIV/AIDS could undermine social and political stability, thus threatening democracy (Ibid, p. 2).

Where urban development planning is unable to provide the services and support required, it is to be expected that the need to develop coping mechanisms falls – to an even larger extent than is currently the case – on the shoulders of already marginalised groups. Women, children (especially orphans), the elderly and the poor are likely to carry disproportionate responsibility for the sick and dying, and for those who are left behind as a consequence of HIV/AIDS. At the same time, they face a real danger of being stigmatised and socially excluded. This, in turn, increases their vulnerability to HIV infection, thus resulting in a vicious cycle of inequality and vulnerability. To break this cycle, inequality and social exclusion need to be addressed.

The preceding discussion has sought to demonstrate that HIV/AIDS has the potential to undermine and reverse development gains. Thus, the effectiveness of development interventions is at stake. Furthermore, it has underscored that HIV/AIDS is closely associated with poverty and impoverishment, disparities and widening inequality, power and vulnerability, stigma and discrimination. Both from the point of view of effectiveness and social justice, HIV/AIDS cannot be ignored in the conceptualisation and realisation of the just city.

HIV/AIDS And The Just City
It could be argued that the realisation of the just city itself can – at least to a certain extent – create an environment in which vulnerability to HIV/AIDS is reduced and HIV/AIDS is better addressed. For example, by reducing inequality and promoting social inclusion, some of the contributing factors to the spread of HIV/AIDS could be addressed. Likewise, effective public sector service delivery within the context of a democratic framework can be considered important conditions to develop an appropriate response to the HIV/AIDS epidemic.

However, promoting the just city is not sufficient in responding to the HIV/AIDS epidemic. For example, whereas a democratic framework may provide the context to develop an appropriate response to HIV/AIDS, it does not in and of itself assure that HIV/AIDS is addressed effectively.[44] Furthermore, HIV/AIDS does not only follow patterns of inequality, it further entrenches these and adds new dimensions of exclusion and discrimination to social relations. Moreover, through its capacity to undermine the urban economy, the capacity of the state and social relations, HIV/AIDS fundamentally alters the nature of urban development. A similar perspective is reflected in a recent UNDP report, which notes:

"The devastation caused by HIV/AIDS is unique because it is depriving families, communities and entire nations of their young and most productive people. The epidemic is

deepening poverty, reversing human development achievements, worsening gender inequalities, eroding the ability of governments to maintain essential services, reducing labour productivity and supply, and putting a brake on economic growth. These worsening conditions in turn make people and households even more at risk of, or vulnerable to, the epidemic, and sabotages global and national efforts to improve access to treatment and care. This cycle must be broken to ensure a sustainable solution to the HIV/AIDS crisis." (UNDP, 2001, p.1)

Therefore, the just city principles need to be interpreted in such a way that recognises the nature and manifestation of HIV/AIDS in the urban context. Unless the multiple impacts of the HIV/AIDS epidemic at individual, household, community, citywide and national level are taken into account, the just city will not be realised.

HIV/AIDS: A Reinterpretation Of The Just City Principles

This section suggests how each just city principle needs to be interpreted to take HIV/AIDS into account. In doing this, I try to avoid repetition of what has been covered in the first two chapters, but will extract the recommendations from the material presented.

Equitable Standard Of Living

The close correlation between HIV/AIDS, poverty and inequality poses a serious challenge to the first just city principle. In particular the potential of HIV/AIDS to enhance impoverishment, increase informalisation of the urban economy and exacerbate inequalities in services, such as health and education, needs to be recognised.

Social Inclusion And Respect For Cultural Identity

The conflation of vulnerability to HIV/AIDS with responsibility for HIV/AIDS has resulted in new forms of blaming, stigmatisation and exclusion. The plight of AIDS orphans is a clear case in point, although youth, women, migrants and other marginal social groups are equally important examples. Recognition of the specific ways in which people living with, or vulnerable to, HIV/AIDS are excluded from social processes is required to achieve this principle.

Democracy

As a consequence of the inability of municipal governments to provide political leadership on HIV/AIDS and to deliver effective public services, social and political instability may occur. Of particular concern is the need to include people living with HIV/AIDS in democratic participatory processes and as elected political representatives and/or those who advocate for them.

Institutional Effectiveness And Efficiency

The depletion of skills and human resources in the government sector due to HIV/AIDS seriously reduces the capacity of municipal governments to provide services in an effective and efficient manner. Moreover, additional demands on relevant authorities for care, treatment and the mitigation of the impacts of HIV/AIDS need to be taken into account in prioritising resource allocations.

Economic Growth With Equity

Growth with equity strategies need to be informed by an understanding that the HIV/AIDS epidemic has the capacity to undermine urban economic growth (through falling productivity, increased labour turnover and probable skills shortages) whilst threatening to increase the informalisation of the urban economy. This stands at odds with the equitable distribution of economic growth.

Spatial Integration

In as far as poverty, inequality (including unequal health status and disparities in service provision) and cultural exclusion are expressed spatially, HIV/AIDS has spatial dimensions. Also, the poor who have a higher proportion of HIV/AIDS are already segregated. Spatial integration in this context then refers to the need for equitable service provision and the need to resist or overcome the segregation of people living with HIV/AIDS, or those presumed to be 'risk groups'.

Ecological Integrity

In relation to ecological integrity, two (fairly controversial) observations have been made. First, it has been suggested that slower population growth due to AIDS deaths will diminish pressures on the environment (Department of Social Development, 2000). Secondly, it has been argued that greater impoverishment may result in an increased reliance on natural resources to meet basic needs, thus leading to greater exploitation of these resources (Ibid). However, the extent to which natural resource use by the poor contributes to environmental degradation has been strongly contested (see, amongst others, Satterthwaite, 1999). Thus, the link between HIV/AIDS and the principle of ecological

integrity is not obvious – other than seeing them as potentially competing priorities.

Conclusion
Whereas the epidemiology of HIV/AIDS crosses social divisions, the sociology of HIV/AIDS is closely associated with social relations of inequality. In this chapter, I identified inequalities at global, national and local level. Within urban areas, age, class, gender (coupled with marital status) and ethnicity/race constitute the most significant factors enhancing vulnerability to HIV infection and the impacts of AIDS. Whereas the realisation of the just city can reduce vulnerability to HIV/AIDS by reducing inequality, promoting social inclusion and creating democratic and effective institutional frameworks, this chapter concluded that this is not sufficient. Instead, the just city principles need to be interpreted in such a way that recognises the devastating impacts of HIV/AIDS on individuals, social relations, the urban economy and local democracy. The next chapter will focus on the nature and manifestation of HIV/AIDS in a context of political transition and explore how the just city model can contribute to an effective response to the HIV/AIDS epidemic in South Africa.

3. HIV/AIDS AS A CHALLENGE TO URBAN DEVELOPMENT IN SOUTH AFRICA

"AIDS and HIV seem likely to replace race and skin colour over the next decade as the major criterion of discrimination and exclusion in our society. The old vectors of discrimination, the old rationales for exclusion, for demeaning treatment of fellow citizens, have become tarnished and unacceptable even to those who formerly defended them. AIDS offers a new symbol, a new focus and a new means of rationalising exclusion and deprivation; a means of insulating ourselves against people's otherness and explaining to ourselves why we deny to them what we would claim for ourselves." (Edwin Cameron, quoted in Marais, 2000, pp. 52-53)

Introduction
South Africa has the highest absolute number of people living with HIV/AIDS in the world and the epidemic is not yet contained. Despite the crisis, an effective government response to the epidemic is marred by political controversies. It is beyond the purpose of this paper to discuss these controversies. Rather, this chapter seeks to explore the nature and manifestation of HIV/AIDS in urban areas within a particular historical and socio-political context. To a certain extent, the South African epidemic shows great similarities with the epidemic in other sub-Saharan Africa. However, patterns of vulnerability to HIV/AIDS and the anticipated impacts of the epidemic also show certain characteristics based on South Africa's history and current social, economic and political trends. A key factor in the spread and manifestation of HIV/AIDS in South Africa is apartheid urban planning. Its legacy still permeates urban areas in the existence of high levels of inequality, spatial fragmentation and social divisions. Current trends such as urbanisation, local democratisation and economic restructuring will also be briefly discussed to highlight some aspects of the complexity of urban development in South Africa. This is followed by a review of two key urban development policy frameworks, the Urban Development Framework and the White Paper on Local Government. Both documents are completely silent on HIV/AIDS. The main reason for this omission seems to be the conceptual framing of HIV/AIDS as predominantly a health issue in South Africa, although other reasons cannot be ignored. It is suggested that the correlation between the policy frameworks and the just city provides an opportunity to overcome this oversight.

The HIV/AIDS Epidemic In South Africa: A Challenge To Urban Development
HIV was first recorded in South Africa in 1982 (Marais, 2000; Whiteside and Sunter, 2000). Within the next decade, HIV shifted from being predominantly a syndrome affecting white homosexual men to becoming a black heterosexual disease.[45] By the end of 1999, 4.2 million South Africans were estimated to be HIV-positive, of which about 52% were women (15-49 years old), about 45% were men and two percent are babies[46] (Department of Health, 2000, p. 6). A year later, by the end of 2000, this figure had further increased to 4.7 million HIV-positive people (Mail & Guardian, 6 June 2001). This increase suggests that almost 1400 people get infected daily.[47] One in four (24.5%) South African adults is estimated to be HIV-positive (UNAIDS, 2001c, p. 7). South Africa now has the highest absolute number of people living with HIV/AIDS compared to any country in the world (Van der Vliet, 2001, p. 152). The majority of infections occur amongst people between 20-44 years old (Whiteside and Sunter, 2000, p. 58). Within this age category, adults between 20-29 years old show the highest HIV prevalence rate.[48] The crisis underneath these statistics is barely

imaginable. Yet, the challenge to the just city – in as far as the epidemic is concentrated in urban areas – is obvious.

As in other developing countries facing a predominantly heterosexually transmitted epidemic, the HIV/AIDS epidemic in South Africa reflects similar patterns of vulnerability according to age, class[49], gender[50] and marital status[51] (and their interplay) as discussed in Chapter 2. In addition, given South Africa's racialised past, race[52] cannot be ignored as a significant factor of inequality and vulnerability. Although the Department of Health (2000) states that it is unable to disaggregate data on HIV prevalence according to population groups, based on the fact that women attending public health clinics are predominantly African, it has been argued that the rate of transmission amongst the African population is substantially higher than amongst other population groups (Abdool Karim, 1998, p. 16). The socio-economic context of the African population, rather than race per se, serves as a plausible factor in explaining the disproportionate extent to which Africans are vulnerable to HIV infection. The close association between HIV/AIDS and race suggests that HIV/AIDS will not necessarily replace race as a factor of discrimination, as Edwin Cameron quoted at the beginning of this chapter argues, but is likely to coincide with it.

Because there is little data to illustrate the exact nature of the relationship between HIV/AIDS and the factors mediating vulnerability, much of the evidence is anecdotal. More research is needed to explore the specific connection between HIV/AIDS and the fault lines of South African society. What is obvious, however, is that the HIV/AIDS epidemic is occurring in a society that is already highly divided and polarised. In this context, the divisive nature of HIV/AIDS has the potential to threaten the prospect of equality and social inclusion that underpin notions such as 'the Rainbow Nation'.[53]

In this context, it is worth noting that the high prevalence rate of HIV/AIDS in South Africa is not caused by ignorance. Instead, despite high levels of public awareness of HIV/AIDS in South Africa[54], there appears to be little change in the sexual behaviour of adolescents (Simbayi, 1999; Van der Vliet, 2000), which is characterised by multiple partners and increased periods of unprotected sex (Abdool Karim, 1998). The factors of vulnerability partly help to explain that engagement in risk behaviour is not always a matter of choice. In addition, these factors need to be interpreted in the context of "people's socially negotiated social and sexual identities" (Campbell, Mzaidume and Williams, 1998, p. 51). Social and cultural values related to motherhood and masculinity (where fathering and high sexual activity are considered positive signs of male virility), to condom use (seen as a token of distrust and a waste of sperm) and to dry sex practices, for example, further facilitate HIV transmission, with women being disproportionately as risk (Abdool Karim, 1998; Campbell, Mzaidume and Williams, 1998).

Moreover, in contexts where the quest for survival is incessant and where injury, illness or death are a daily occurrence, the invisible and long-term threat of HIV seems fairly irrelevant. This observation has been made in relation to miners (Campbell, Mzaidume and Williams, 1998), commercial sex workers (Ibid) or others engaged in survival sex (Adams and Marshall, 1998), those living in areas where political violence has been high (Van der Vliet, 2000), girls engaged in youth gangs (Adams and Marshall, 1998), women in (potentially) violent relationships (Abdool Karim, 1998; Tallis, 1998) and "people in settings that seem to foreclose on the future" (Marais, 2000, p. 47).

The Spatial Manifestation Of HIV/AIDS

Contrary to trends in other African countries, the HIV epidemic appears to spread as rapidly in urban and in rural areas (UNDP-SA, 1998; Whiteside and Sunter, 2000). Instead, regional differences are more significant than an urban-rural distinction. Table 3.1 compares the proportion of urban population per province with the provincial HIV prevalence rate and the rate of increase. It is clear that the HIV epidemic is at different stages in different parts of the country, with HIV prevalence rates varying from 32.5% in KwaZulu-Natal to 7.1% in the Western Cape. Moreover, provincial HIV prevalence rates in the Northern Cape and the Western Cape, two of the three most urbanised provinces, are the lowest in the country. However, despite having the lowest prevalence rate, the Western Cape is noting the highest rate of increase at 36.5%, whereas the Northern Cape shows a slight increase. As will be discussed below, migration patterns help to explain the provincial differences and the parallel spread of HIV/AIDS in urban and rural areas.

Table 3.1 Proportion of urban population and rate of HIV prevalence and incidence per province			
Province	Proportion of urban population, 1996	HIV prevalence in 1999	HIV rate of increase 1998-1999
Eastern Cape	37%	18.0%	13%
Free State	69%	27.9%	22%
Gauteng	97%	23.9%	6%
KwaZulu-Natal	43%	32.5%	0%
Mpumalanga	39%	27.3%	-9% [I]
North West	35%	23.0%	8%
Northern Cape	70%	10.1%	2%
Northern Province	11%	11.4%	-1%
Western Cape	89%	7.1%	37%
National	54%	22.4%	n/a

[i] The sudden decrease in Mpumalanga may be attributed to the sampling method.
Sources: SAIRR (1999) and Department of Health (2000)

Specific data on the manifestation and impact of HIV/AIDS in urban areas appears to be unavailable. This is partly indicative of a history of inadequate data collection in South Africa.[55] Thus, this information has to be inferred from general data. Yet, national statistics also have to be approached with a certain amount of circumspection. As in developing countries in general, data on HIV/AIDS in South Africa is largely based on modelling techniques rather than direct observation (Department of Social Development, 2000). Because this data is extrapolated from women attending antenatal clinics, there are inherent biases as women attending these clinics are disproportionately African (Department of Health, 2000) and relatively young (Whiteside and Sunter, 2000).[56] Moreover, HIV-positive women are likely to be under-represented, because HIV-infection results in a decline in fertility (Ibid, p. 33). Also, although South Africa now provides data regarding the annual HIV incidence rate, amongst others, the date when people discover they are HIV-positive does not necessarily correspond to the year in which they were infected (Ibid, p. 29). According to the Department of Social Development (2000, p. 62), underreporting of HIV-infection and AIDS-related deaths has been common, with only slightly more than one percent of AIDS deaths recorded in 1995.

A further word of caution relates to the use of the term 'urban areas'. Whilst this chapter will refer to urban areas in a fairly generalised sense, it is important to bear in mind that urban areas in South Africa display a variety of settlement types which differ in size, population density, levels of infrastructure and service provision, location, status (formal/informal) and economic base.[57] This variety complicates a discussion about urban development and the impact of HIV/AIDS on urban areas in general terms.

Impacts on urban development

Whilst the exact nature and manifestation of HIV/AIDS in urban areas may not be known, it is clear that the impacts of the epidemic in South Africa will be similar to those discussed in Chapter 2. As in other developing countries, the epidemic will negatively affect health and life expectancy, poverty and inequality, productivity and the urban economy, and the ability of the state to provide public services. This clearly jeopardises the realisation of the just city. Box 3.1 summarises the observed and anticipated impacts of the HIV/AIDS epidemic in South Africa. However, it has been suggested that the impact of the epidemic will be more severe in South Africa than in other countries because of the scale of the epidemic, the high levels of inequality, and because South Africa has a relatively sophisticated economy, which makes it more vulnerable to the effects of the epidemic (UNDP-SA, 1998; Whiteside and Sunter, 2000).[58] Thus, despite similarities with the epidemic on the African continent, HIV/AIDS as manifested in urban areas in South Africa has certain characteristics based on South Africa's particular history and the current social, economic and political context. It is to

these historical and current aspects that we now turn our attention.

Box 3.1 Impacts of the HIV/AIDS epidemic in South Africa

- An increase in adult mortality and child mortality, resulting in an anticipated drop in life expectancy from 68.2 years to 48 years by 2010 (UNDP-SA, 1998, p. 5);
- A change in the gender ratio, with men expected to outnumber women in the future (Whiteside and Sunter, 2000), raising questions about the future status of women;
- A reduction in household income, an intensification of poverty and inequality, and the disintegration of households (Department of Social Development, 2000; UNDP-SA, 1998);
- An estimated two million AIDS-orphans by 2010, associated with an increase in child-headed households (Whiteside and Sunter, 2000);
- A collapse of educational systems due to a drop in school attendance and staff losses (UNDP-SA, 1998);
- Stress on an already overstretched public health system, thereby reducing its potential to provide quality health care (UNDP-SA, 1998);
- A noted increase in tuberculosis (Department of Social Development, 2000; Whiteside and Sunter, 2000), which will threaten the health of both HIV-positive and HIV-negative people;
- A decline in productivity and loss of skills and experience: by 2003, 12% of highly skilled workers, 20% of skilled workers and 27.2% of low-skilled workers are expected to be HIV-positive (Department of Finance, quoted in Whiteside and Sunter, 2000, p. 88);
- An anticipated reduction in real GDP growth by 0.3% in 2005 and a decline in the annual GDP growth rate of one percent per capita by 2010 (UNAIDS/UNECA, 2000, p. 196);
- A weakened capacity of the state to respond to increased demands for support and service provision due to loss of human resources and skills (Whiteside and Sunter, 2000) and the high cost associated with HIV/AIDS: it has been estimated that by 2010, the AIDS epidemic will have cost the South African economy more than $22 billion (Nevill, 2001);
- Social instability, as people who fulfil roles as 'role models' are disproportionately eliminated (Department of Social Development, 2000), and the state proves ineffective in stemming the epidemic and mitigating its impacts;
- Increased burden of care on women, children and the elderly in the absence of adequate state support (Department of Social Development, 2000);
- Stigmatisation, social exclusion and a potential breakdown in already fragile social relations (Marais, 2000; UNDP-SA, 1998).

Contextualising The Epidemic

It would be a mistake to assume that HIV/AIDS is a post-apartheid syndrome. As Van der Vliet (2001) argues, it is the youth of the turbulent 1980s, now in their twenties and thirties, who show the highest infection rates. Apartheid, in particular apartheid urban planning, is a significant factor in the spread and manifestation of the HIV/AIDS epidemic in South Africa.

Historical Factors: Apartheid Ideology And Urban Planning

Whilst evidence suggests that the epidemic is spreading as rapidly in urban as in rural areas, apartheid urban planning has been instrumental in facilitating the spread of HIV/AIDS. Apartheid was characterised by domination, separation and control, in which urban planning was used as an instrument to restrict the number of black people in what was considered 'white' South Africa and to segregate urban residential areas for different population groups. African migrants were allowed to stay in urban areas only for as long as they served a purpose for the white-dominated economy (Smith, 1992). Government policy of 1967 stated that "Bantu [i.e. Africans] are only temporarily resident in European [i.e. white] areas for as long as they offer their labour there. As soon as they become, for some reason or other, no longer fit to work or superfluous in the labour market they are expected to return to their country of origin [i.e. 'homelands']" (quoted in Whiteside and Sunter, 2000, p. 62). This also implied an assumption that they would preferably be single-migrant workers, whose families would be living in their respective 'homelands' (Smith, 1992). In 1985, there were close to two

million South Africans who worked as migrants (Whiteside and Sunter, 2000, p. 63), the majority of whom were male (Department of Social Development, 2000).

The migrant labour system, a cornerstone of apartheid urban planning, has been identified as a major contributing factor to the spread of HIV/AIDS (Department of Social Development, 2000; UNDP-SA, 1998; Whiteside and Sunter, 2000). It led to the fragmentation of social structures, in particular of the family, especially amongst the African population (Department of Social Development, 2000; Whiteside and Sunter, 2000). As Mark Lurie (quoted in UNAIDS, 2001c, p. 6) commented: "If you want to spread a sexually transmitted disease, you'd take thousands of men away from their families, isolate them in single-sex hostels, and give them easy access to alcohol and commercial sex. Then, to spread the disease around the country, you'd send them home every once in a while to their wives and girlfriends."

Apartheid urban planning was not only characterised by racial segregation, control and restriction of African urbanisation. The differential value attached to different race groups meant that black residential areas were deliberately under-serviced and that few commercial and recreational activities were allowed. This undermined the ability of these areas to achieve an economic base and maintain or extend basic services (McCarthy, 1992). Despite strong state attempts for planning control, many informal settlements sprung up, most of them located on the periphery of urban areas to avoid state harassment (Dewar, 1992). The existence of severe infrastructural disparities within urban areas, with a poor quality built environment characterising low-income and informal settlements, still attests to this historical neglect.

The apartheid government was aware of HIV/AIDS, yet proved ill-prepared to respond to the epidemic (Van der Vliet, 2001). The inability of the apartheid government to curb the epidemic has been attributed to two, mutually reinforcing, factors. On the one hand, there was government denial and a lack of interest to deal with the epidemic, since it affected 'discredited' or 'insignificant' groups, like homosexuals and black people (Simbayi, 1999; Van der Vliet, 2001). On the other hand, there was public suspicion of the apartheid government, where the majority of Africans saw AIDS awareness campaigns as an attempt of the apartheid state to curtail African population growth (Ibid). Also, in a context of political turmoil and the struggle against apartheid, the invisible AIDS epidemic was not taken seriously (Ibid).

Current Urban Realities

HIV/AIDS is currently the subject of political controversies in South Africa, which clearly hinders the democratic government's capacity to stem the HIV/AIDS epidemic and mitigate its impacts. Whilst recognising that the political context is a critical factor, it is beyond the scope of this paper to analyse these controversies.[59] The focus here is to assess the complexity of urban development challenges in post-apartheid South Africa within the context of the HIV/AIDS epidemic. Urban areas in South Africa are simultaneously products of the past and places of social, political and economic change.

Products Of The Past: Inequality, Fragmentation And Alienation

Whereas apartheid has been abolished, its ideology and planning interventions have left an indelible mark on the urban landscape. As products of the past, South African cities reflect marked socio-economic inequalities, spatial fragmentation and segregation (with race and class still largely overlapping as dividing factors), and cultural alienation. These characteristics and trends – in direct contrast with the just city ideal – constitute fertile ground for the spread of the HIV/AIDS epidemic.

Despite being classified as a middle income country, South Africa is characterised by high levels of poverty and inequality (UNDP-SA, 1998). According to World Bank data of 2000, South Africa has the sixth highest income inequality in the world, with a Gini index[60] of 59.3 (UNCHS, 2001, p. 18). Although this indicates a drop from second place in 1996, in fact the Gini index has increased from 58 (May, 2000, p. 26). In interpreting this, we find that the poorest 40% of households (constituting 50% of the population) receive 11% of the total income, whereas the richest 10% of households (constituting seven percent of the population) receive 40% of the total income (Ibid, p. 27). Table 3.2 shows that whereas urban inequality between population groups has decreased, there has been an increase in inequality within population groups classified as black[61]. Over 40% of the population live below the poverty line of R 353[62] per month (UNDP-SA, 2000, p. x). Poverty is most prevalent in rural areas (over 50%), amongst the African population

(57%) and amongst female headed households (60%) (Ibid). The poverty rate for all urban households is 24%, with clear discrepancies between different urban areas (May and Rogerson, 2000, p. 209). Depending on what definition of unemployment[63] is adopted, urban unemployment rates vary between 22% and 33% (SAIRR, 1999, pp. 306-307). The highest rate of urban unemployment occurs amongst the African population (between 29-43%), followed by the Coloured population (18-25%), Indians (10-13%) and Whites (4-7%) (Ibid).[64] In general, social exclusion and vulnerability coincide with racial and gender lines. This reality stands in direct contrast with the just city principle of an equitable standard of living.

Table 3.2 Income inequality by population group: Gini coefficient, 1990 and 1995

Population group head of household	12 main urban areas		Whole country
	1990	1995	1995
African	0.35	0.51	0.52
Coloured	0.37	0.42	0.50
Asian	0.29	0.46	0.44
White	0.50	0.44	0.49
All households	0.63	0.55	0.59

Source: Department of Social Development (2000), p. 10

The spatial expression of inequality has already been referred to. In post-apartheid South Africa, spatial segregation continues to feed cultural divisions. In this context of cultural alienation and social polarisation, 'othering' of people living with HIV/AIDS, or potential risk groups, has been a common response (Marais, 2000). The close association of HIV/AIDS with race is likely to further strain fragile intercultural relations. As such, the just city principles of social inclusion and spatial integration are under threat.

The bi-directional relationship between poverty/inequality and HIV/AIDS has been discussed in Chapter 2. The government's main response to poverty and inequality has been to promote economic growth through the pursuit of a neoliberal macroeconomic approach. However, since the democratic transition economic growth has been very slow.[65] Moreover, it represents "jobless growth" (Department of Social Development, 2000, p. 20), which means that modest growth has been accompanied by declining employment opportunities, especially amongst semi-skilled and unskilled labourers.[66] Increasing levels of urban unemployment are resulting in growing economic informality (Beall, Crankshaw and Parnell, 2000).

Places Of Change: Urbanisation, democratisation and economic restructuring

Urban areas in South Africa are also places of social, political and economic change, partly reflected in trends such as urbanisation, local democratisation and economic restructuring.

Table 3.1 shows that 54% of the South African population is urbanised, with great differential patterns of urbanisation between the provinces.[67] Urban areas continue to grow, both as a consequence of natural population growth and increased urbanisation (Ministry for Provincial Affairs and Constitutional Development, 1998). The majority of migrants come from rural areas, with the two most urbanised provinces in the country receiving over 400 000 migrants in the period between 1992 and 1996 (Department of Social Development, 2000, p. 18).[68] Given the culturally diverse backgrounds of migrants, urbanisation is associated with increased cultural diversity in urban areas. People between 15-44 years old are particularly inclined to migrate, with a peak around age group 25-29 years old (Ibid). Research in KwaZulu-Natal has demonstrated that migration, especially circular migration, increases the risk of HIV infection about three-fold (Abdool Karim, 1998, p. 17).

Another aspect of change relates to the dual process of local democratisation and decentralisation that has occurred in post-apartheid South Africa. Because local authorities were key instruments of apartheid planning, they became the focal point of grassroots resistance in black communities in the 1980s (Younge, 1999). With the establishment of democratic municipal organisations and the transformation of the local government system, there is an expectation that municipalities will be better equipped to address the complexity of urban development challenges. This development seems compatible with the just city principles of democracy and institutional effectiveness and efficiency. However, although not as strong as in the past, public scepticism and distrust of local government is still prevalent today (Patel, 2000).

The economic dimension of change is reflected in the transition of the urban economy in accordance with processes of national economic restructuring and global economic change. Urban areas account for 80 percent of South Africa's Gross Domestic Product (GDP) (Department of Housing, 1997, p. 2), thus they are highly significant for the national economy and national development interventions. The neoliberal macroeconomic approach pursued by the South African government has led to a decline of some and the growth of other urban economic sectors, resulting in growing economic informality, inequality and urban poverty (Beall, Crankshaw and Parnell, 2000). The adoption of the just city principle of economic growth with equity could help to remedy this situation.

The scale, nature and manifestation of HIV/AIDS in South Africa's urban areas necessitates that urban development planning takes it into account. The following section will review the government's main urban development frameworks.

National Policy Frameworks For Urban Development

The two most significant South African policy documents for urban development are the Urban Development Framework (UDF) (Department of Housing, 1997) and the White Paper on Local Government (WPLG) (Ministry for Provincial Affairs and Constitutional Development, 1998). Although the last mentioned document is not restricted to urban local government or urban development per se, it is significant because "municipalities are at the coal face of managing the urbanisation process and initiating and facilitating urban development in consultation and in partnership with stakeholders" (Department of Housing, 1997, p. 5). For the purpose of this paper, the analysis presented here will be restricted to matters related to urban development in the WPLG.[69]

It is astonishing that both policy frameworks – both developed in the latter half of the 1990s when the national Health Department estimated that already one in eight adults was HIV-positive (Marais, 2000, p. 1) – are completely silent on the issue of HIV/AIDS. The main reason for this omission seems to be the conceptual framing of HIV/AIDS as predominantly a health issue in South Africa (Marais, 2000; Van der Vliet, 2001), although other reasons are also significant.[70]

In the absence of a clear recognition of the significance of HIV/AIDS for urban development, it could be useful to explore, firstly, whether there is a correlation between the two policy frameworks and the just city, and, secondly, whether this correlation would allow for an insertion of HIV/AIDS into urban development planning in South Africa. The remainder of this chapter will focus on these interrelated questions.

Utopian Thinking As A Hallmark

One could argue that utopian thinking, as discussed in Chapter 1, is a hallmark of both the UDF and the WPLG. Both include an analysis of current realities, informed by a historical perspective, which is followed by a vision for the future.

Analysis Of Urban Realities

The UDF (Ibid, p. 3) refers to urban areas as "dysfunctional" as a consequence of apartheid policies and planning. It adds that current urban structures reflect both South Africa's unique history of apartheid and current global trends. The 'dysfunctionality' of urban areas is evidenced in urban sprawl, disparate levels of service provision, low levels of suburban population density, and the concentration of the poor in relatively high density areas on the urban peripheries and the wealthy in the core and intermediate areas (Ibid). More specifically, the UDF highlights the following characteristics of urban realities in South Africa:

a large and growing urban population, with different provinces showing different levels of urbanisation;
persistence of inequality and poverty, with stark disparities particularly pronounced in larger urban areas;
financial pressures on municipalities to provide infrastructure to low-income settlements;
a vibrant and dynamic civil society;
economic and financial potentials for urban revitalization, with well-functioning urban economies particularly in metropolitan areas.

The WPLG equally recognises these trends and challenges. Chiefly concerned with the transformation of the local government system in accordance with the political changes of the 1990s, the WPLG further emphasises problematic relations between municipalities and communities, organisational ineffectiveness and entrenched modes of decision-making, and inability to leverage private sector resources as traits of the existing system (Ministry for Provincial Affairs and Constitutional Development, 1998).

Box 3.2 Urban Vision 2020

The Urban Development Framework (UDF) (Department of Housing, 1997, p. 8) articulates a vision of urban areas that will be:

1. Spatially and socio-economically integrated, free of racial and gender discrimination and segregation, enabling people to make residential and employment choices to pursue their ideals;
2. Centres of economic, environmental and social opportunity where people can live and work in safety and peace;
3. Centres of vibrant urban governance, managed by democratic, efficient, sustainable and accountable metropolitan and local governments in close association with civil society and geared towards innovative community-led development;
4. Environmentally sustainable, marked by a balance between quality built environment and open space; as well as a balance between consumption needs and renewable and non-renewable resources;
5. Planned for in a highly participative fashion that promotes the integration and sustainability of urban environments;
6. Marked by housing, infrastructure and effective services for households and business as the basis for an equitable standard of living;
7. Integrated industrial, commercial, residential, information and educational centres which provide easy access to a range of urban resources;
8. Financed by government subsidies and by mobilising additional resources through partnerships, more forceful tapping of capital markets, and via off-budget methods.

A Vision For The Future

The UDF articulates an urban vision for 2020, based on its analysis of current urban trends and characteristics (See Box 3.2). The WPLG, to the extent that it is concerned with the role of local government in realising this vision, envisions a future where local government is "developmental"[71] (Ministry for Provincial Affairs and Constitutional Development, 1998, p. 31). Representative and participative democracy, redistribution and institutional transformation towards the establishment of more effective, efficient and responsive municipalities are key themes of the policy. Like the UDF, it expresses particular concern with the need to provide infrastructure and services and to create integrated settlements (Ibid, p. 36). The WPLG displays a stronger emphasis on social diversity and social inclusion than the UDF. For example, it states that:

"… these 'communities' and 'households' are not homogeneous categories in which everyone is the same. Different people have different starting points in life – determined by factors such as gender, class and race – and different opportunities to access resources and influence decision-making. Within communities and households, power dynamics can develop which see some people gain access to resources and power, and others marginalised or excluded" (Ibid, 1998, p. 28).

Comparing The Urban Vision 2020 To The Just City

Whereas the UDF and the WPLG emphasise different issues, they share a similar analysis of the present and vision for the future. Clearly, the WPLG is specifically concerned with effective urban (and rural) management within a democratic framework. Bearing in mind that some of the just city principles are more explicitly articulated in the WPLG, I will focus the discussion on a comparison of the urban vision 2020 with the just city.

Table 3.3 Comparison of the just city with the urban vision 2020	
Just city principle	*Characteristics of future urban areas*
1. Equitable standard of living	Provision of infrastructure and services (6) and centres of opportunity (2)
2. Social inclusion	Socio-economic integration, free of racial and gender discrimination and segregation (1) Centres of opportunity (2)
3. Democracy	Centres of vibrant urban governance (3) and outcome of participative planning process (5)
4. Institutional effectiveness and efficiency	Centres of vibrant urban governance, managed by … efficient … governments (3) and partnerships (8)
5. Growth with equity	Financed by government subsidies and … more forceful tapping of capital markets (8)
6. Spatial integration	Spatial integration (1) and integrated centres of urban resources (7)
7. Ecological integrity	Environmental sustainability (4)

A comparison between the urban vision 2020 and the just city principles shows a certain amount of overlap. The first characteristic corresponds with the principles of social inclusion and spatial integration, whereas the second relates to the principle of an equitable standard of living. It could even imply social inclusion and respect for cultural diversity, which is the second just city principle. The principle of democracy, interpreted as both representative and inclusive participative democracy, is consistent with the third feature of vibrant urban governance and with the emphasis on the ideal city as the outcome of a highly participative process in the fifth characteristic. The third feature also corresponds with the principle of institutional effectiveness and efficiency, although it emphasises efficiency. The ideal of environmentally sustainable cities correlates with the just city principle of ecological integrity. The attribute of an equitable standard of living literally corresponds with the first just city principle. The last point related to the financial basis of urban development suggests, amongst others, an approach based on growth with equity. Its emphasis on partnerships could be interpreted to correlate with the principle of institutional effectiveness and efficiency. The correlation between the just city principles and the 'urban vision 2020' is summarised in Table 3.3.

From the analysis presented so far, we can draw two conclusions. First, the just city framework has great relevance for the South African context. Secondly, it has common characteristics with existing South African frameworks for urban development. This correlation allows for a reinterpretation of the 'urban vision 2020' in accordance with the interpretation of the just city principles based on an understanding of the nature and impact of HIV/AIDS, as presented in Chapter 2.

Box 3.3: The urban vision 2020 and HIV/AIDS

1. Urban areas will only become integrated, free of discrimination and enabling people to pursue their ideals if it is recognised that HIV/AIDS is associated with stigma and discrimination, and if the socio-economic needs of people living with HIV/AIDS, their families and their communities are addressed.
2. For urban areas to become centres of economic, environmental and social opportunity, the threat of HIV infection needs to be reduced by counteracting factors of vulnerability. In particular, it requires a focus on the informalisation of the urban economy as a result of the epidemic.
3. Urban areas can only become centres of urban governance, if political recognition is given to HIV/AIDS. This also requires that people living with HIV/AIDS and organisations working on HIV/AIDS are represented at political and administrative levels.
4. Urban areas can only become environmentally sustainable, if it is recognised that the built environment itself can enhance vulnerability to HIV/AIDS (e.g. by the lack of urban services and infrastructure, or by creating spaces that increase the threat of rape and sexual violence).
5. Urban areas can only be considered the outcome of participative planning if the perspectives and experiences of people living with HIV/AIDS and advocates on HIV/AIDS are included in the decision-making process.
6. Urban service delivery can only be considered effective if it contributes to the reduction of vulnerability to HIV infection and helps alleviate the impacts of AIDS.
7. Urban areas can only become integrated centres if the spatial manifestation of HIV/AIDS is addressed.
8. In determining spending priorities, the multiple devastating impacts of HIV/AIDS need to be taken into account. Because HIV/AIDS will add enormous financial pressures on the government, additional sources will need to be tapped into. In seeking to mobilise resources, the private sector needs to be encouraged to accept social responsibility for the HIV/AIDS epidemic.

Breaking the silence

Given the silence on HIV/AIDS in national frameworks for urban development, it is not surprising that many municipalities have not accepted sufficient responsibility in addressing the HIV/AIDS epidemic (Whiteside and Sunter, 2000). A survey amongst four main urban areas highlights that an effective, comprehensive approach to HIV/AIDS in urban development planning suffers, amongst others, from a misconstruction of HIV/AIDS as a health issue, a lack of organisational awareness of the developmental impacts of the epidemic, and intergovernmental tensions regarding responsibilities and resource allocation (Thomas and Crewe, 2000).[72] It is noteworthy that both the Department for Provincial and Local Government (which also has responsibility for disaster management) and the South African Local Government Association (SALGA) appear silent on the issue.[73]

The question is what the prospects for change are. In light of this, it is worth noting that some have already expressed scepticism whether the visions expressed in the UDF and WPLG will be realised (Dewar, 1998; Donaldson, 2000; Mabin, 2000).[74] Evidence suggests that in recent years, urban development planning has in many instances resulted in increased inequalities and "resegregation" (Donaldson, 2000, p. 52), thereby undermining the prospect of transforming urban areas in line with the just city principles. To be fair, it may not be realistic to expect that a legacy of many decades can be addressed in a few years time, especially when these last few years have been characterised by a process of redesigning urban development frameworks and systems to better address the complexities of urban development planning in South Africa.

However, despite the lack of strategic direction in urban development policy frameworks and despite the confounding nature of urban development planning in South Africa, it is both necessary and possible to take account of the HIV/AIDS epidemic in urban development planning. It is *necessary*, because HIV/AIDS "threatens to reverse progress in human development and the promotion of a representative and participative democracy" (UNDP-SA, 1998, pp. 3-4). Unless recognised as a key component of urban development, HIV/AIDS will thwart the realisation of the urban vision 2020 and undermine the creation of developmental local government. It is *possible*, because of the compatibility between utopian thinking informing urban development planning in South Africa and the just city principles, provided these are interpreted in such a way that recognises the nature and manifestation of HIV/AIDS in urban areas (see Box 3.3). Amidst the complexities of urban development, HIV/AIDS could arguably become the central issue in urban development planning to promote integrated and socially just urban

development. As a starting point, what is required is for HIV/AIDS to be reconstructed as an urban development concern and not merely a health issue (see Box 3.4).

Conclusion

HIV/AIDS is possibly the most significant urban development challenge facing South Africa. It has the potential to undermine urban development efforts through its devastating impacts on the health and well being of urban residents, on social relations, on the capacity of the local state to deliver services, on local democracy and on the urban economy. Furthermore, it is intricately linked to social justice: not only does HIV/AIDS tend to follow existing patterns of vulnerability, it also entrenches inequality and places further strain on fragile social relations. In a context already characterised by high levels of polarisation and inequality, this poses a real threat to social and political stability. This chapter has identified apartheid urban planning as a key factor in the spread and manifestation of the HIV/AIDS epidemic in South Africa. Recent policy frameworks seeking to overcome the legacies of apartheid urban planning whilst responding to new urban trends and challenges have so far ignored HIV/AIDS. Similarly, the responses by urban municipalities, where they exist, have tended to be confined to health- and prevention-related interventions. A first step in developing a more effective response to HIV/AIDS is to reconstruct it as an urban development concern. Because of their compatibility with South African urban development policy frameworks, the just city principles – interpreted through a 'HIV/AIDS lens' – can serve as a normative framework for urban transformation in South Africa. As such, HIV/AIDS can become a central issue in urban development planning to promote integrated and socially just urban development.Conclusion

Box 3.4 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, p. 15)

HIV/AIDS is a human tragedy. It is also a development crisis of global proportions. To the extent that the HIV/AIDS epidemic has concentrated in urban areas, it poses a critical challenge to urban development planning in developing countries, especially in sub-Saharan Africa. It has the capacity to undermine urban development through its devastating impacts on health and well being, social relations, the urban economy and local democracy. HIV/AIDS threatens to destabilise the social fabric in communities by disintegrating households, entrenching inequalities and impoverishment, and giving rise to stigmatisation and marginalisation of perceived high-risk groups. HIV/AIDS follows patterns of vulnerability, associated with factors such as age, class, gender and race/ethnicity, and further entrenches social divisions based on these factors and their interplay. Thus, the relationship between HIV/AIDS and inequality is bi-directional. As the epidemic progresses, it erodes the capacity of the state to develop an effective response by creating a dual pressure of increased demand for state support and reduced human resources in the public sector to handle this demand. State ineffectiveness and perceived lack of political leadership in responding to the crisis is likely to challenge the legitimacy of the state in the eyes of hard-hit communities, thus resulting in political instability. This undermines the prospect of political participation of people living with and affected by HIV/AIDS. Already, there is little evidence that people living with HIV/AIDS are encouraged to participate in decision-making processes. Furthermore, the association of HIV/AIDS with inequality and impoverishment suggests that those affected by HIV/AIDS may not be in a position to be politically active, unless their basic needs are met. The loss of skills and human resources, reduced levels of productivity and an associated increase in staff-related costs related to replacement, sick leave and benefits will negatively affect the urban economy, with some sectors likely to be more affected than others. Both from the point of view of effectiveness and social justice, HIV/AIDS cannot be ignored in urban development planning.

These grave implications of the HIV/AIDS epidemic for urban development have not been sufficiently recognised, neither

in developing countries in general nor in South Africa in particular. The traditional conceptualisation of HIV/AIDS as a health issue largely serves to explain this oversight. Additional factors in explaining why HIV/AIDS is not addressed in urban development planning include: i. the invisibility of HIV/AIDS, which allows one to ignore its gravity and misunderstand its nature and impact; ii. the politically sensitive nature of HIV/AIDS; iii. the complexity of HIV/AIDS; and iv. the complex nature of urban development. Combined, these factors allow for a disregard of concerns that appear less immediate or a diminution of their significance to sectoral problems. In the case of HIV/AIDS, its traditional conceptualisation as a health issue further permits such a partial approach. More recently, there is evidence of a shift in international debates to a broader conceptualisation of HIV/AIDS as a development concern. This conceptual shift has not yet permeated South African policy frameworks on urban development.

The exact nature and manifestation of HIV/AIDS depends on the social, political and economic context in which the epidemic occurs. Clearly, it is not only the epidemiology of HIV/AIDS, but the social context in which it occurs that warrants investigation. In South Africa, apartheid urban planning is a key factor in the spread and manifestation of the HIV/AIDS epidemic in South Africa. It has resulted in a particular spatial manifestation of HIV/AIDS and in a disproportionate distribution of the burdens associated with the epidemic amongst the black, particularly African, population. Apartheid urban planning has left a legacy of high levels of inequality, spatial fragmentation and intercultural alienation. Recent changes in the national and global political economy tend to reinforce, rather than transform, this legacy. Given the highly polarised nature of South African society, the relatively fragile local democracy and the negative impacts of the restructuring of the urban economy, the destabilising nature of HIV/AIDS is likely to further compound the complexity of urban development.

The question is whether urban development planning is able to develop an appropriate response to HIV/AIDS. It is of concern that mainstream urban development planning has proven to be incapable of adequately dealing with the issue of inequality. In an attempt to overcome this deficiency, I have proposed a set of just city principles as a normative framework for urban development planning. The just city model also proves useful in the context of the HIV/AIDS epidemic. To a certain extent, the realisation of the just city can create the conditions for reducing vulnerability to HIV/AIDS and responding more effectively to the epidemic. However, a more effective approach requires that the just city principles are interpreted in such a way that recognises the devastating impacts of HIV/AIDS on individuals, social relations, the urban economy and local democracy.

Given the high levels of inequality and the scale of the HIV/AIDS epidemic, the just city model has particular relevance for South Africa. Although South African policy frameworks on urban development are completely silent on HIV/AIDS, their compatibility with the just city principles provides an opportunity to incorporate HIV/AIDS into urban development planning, provided these principles themselves are interpreted in such a way that recognises the nature and manifestation of HIV/AIDS in urban areas. For this to happen, HIV/AIDS needs to be reconstructed as a development concern and not merely a health issue.

My journey of investigation has ended in demonstrating that my initial research proposition was correct: because in South African public policy HIV/AIDS is predominantly construed as a health issue, urban development strategies in South Africa are not sufficiently taking into account the destabilising effects of the HIV/AIDS crisis on the social fabric in communities, on political participation and on the urban economy. To prove this proposition, I embarked on various diversions. I looked at the nature and manifestation of HIV/AIDS in sub-Saharan Africa, the broader terrain of urban development planning in developing countries, and the usefulness of the just city model to provide an ethical base to the quest for cities that contribute to an enhanced quality of life and equality.

One of the frustrations on this journey was the lack of reliable data and analysis on HIV/AIDS globally and in South Africa, particularly from a social sciences perspective. Further research is needed on the historical determinants of the HIV/AIDS epidemic, the significance of factors of vulnerability within a specific socio-political context and the impact on social relations, the effect of the epidemic on specific sectors of the urban economy, and the political and institutional implications, to mention but a few. This data and analysis is essential for the development of urban development planning frameworks and strategies that will be effective in taking the multiple and destabilising impacts of the HIV/AIDS epidemic into account. Some

specific questions that warrant urgent investigation include:
What is the social, cultural and economic location of social groups in urban areas that demonstrate disproportionately high levels of vulnerability to HIV/AIDS, such as migrants and their families?
How does HIV/AIDS affect social support systems at household or community level and how does the epidemic impact on social relations?
What is the observed or projected impact of HIV/AIDS on specific urban development indicators and what are the policy implications of this?
What are the elements of, and necessary conditions for, an effective institutional response to HIV/AIDS in a particular urban context?

With an infection rate of close to one person per minute, countries like South Africa urgently need an answer to these questions. It is high time that HIV/AIDS is recognised as the missing element in urban development planning.

Addendum

Examples Of How Urban Development Planning Can Aggravate Vulnerability To HIV/AIDS

Provision of single-sex hostels for migrants
Inadequate or unequal service provision (e.g. housing, basic services, health, education and social services)
Pursuit of economic growth strategies based on reduction of labour demand Construction of main transport routes
Creation of open fields, secluded public spaces and lack of street lights, which enhance the possibility of sexual violence
Spatial segregation of perceived 'high risk groups' or HIV-positive people

Examples Of How Urban Development Planning Can Mitigate Vulnerability To HIV/AIDS

Equitable provision of essential community services (e.g. health, welfare and education)
Provision of affordable housing and basic services for new entrants into the city
Provision of work opportunities for spouses and community services to prevent disintegration of families through migrancy
Promotion of economic empowerment of women through Local Economic Development and Public Work programmes
Reduction of gender and economic disparities that fuel the spread of HIV/AIDS
Urban design and housing design to reduce vulnerability to HIV infection and in recognition of the impacts of HIV/AIDS (see box 3.4)
Provision of vocational training opportunities for youth
Social inclusion strategies to help reduce risk of HIV infection and its negative consequences
Strengthening the involvement of people living with HIV/AIDS in decision making processes
Reduction of stigma and fear by giving a face and voice to HIV/AIDS through the involvement of people living with HIV/AIDS

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ENDNOTES

[1] HIV stands for Human Immunodeficiency Virus. AIDS stands for Acquired Immunodefiency Syndrome.
[2] Other main modes of transmission not explicitly discussed in this paper are sexual transmission among men who have sex with men (MSM) and injecting drug use (IDU).
[3] HIV attacks the immune system. Once the immune system is so weak that it cannot fight infections to which it would normally be resistant, the person has AIDS.
[4] Sub-Saharan Africa hosts 25 out of 28 countries with HIV prevalence rates higher than four percent of the adult population; out of 11 countries with prevalence rates of higher than 13 per cent, eight are located in Southern Africa (UNDP, 2001, p. 3).
[5] Globally, 47% of adults living with HIV/AIDS and 47% of new adult infections occur among women (UNAIDS/WHO, 2000). However, the incidence and prevalence rates amongst women are expected to increase as epidemics progress in other parts of the world (Ibid).
[6] Mother-to-child transmission, or vertical transmission, can occur during pregnancy, childbirth and via breastfeeding (CIIR, 1999). In sub-Saharan Africa, there are 1.1 million HIV-positive children (UNAIDS, 2001c, p. 7). Nine out of ten HIV-positive children are infected through MTCT (UN Regional Task Force on Prevention of Mother-to-Child Transmission of HIV, 2001).
[7] Epidemiologists distinguish between 'prevalence', which refers to the number of people infected in a population, and 'incidence', which refers to the rate at which people become infected (Epstein, 2001).
[8] As UNAIDS (2001c) has cautioned, migration should not be perceived of as the cause, but rather as a risk factor in the spread of HIV/AIDS.
[9] Refugees and internally displaced persons also constitute a category of vulnerable groups to HIV/AIDS (UNAIDS, 2001a).
[10] See, amongst others, UNAIDS (2001c), UNDP (2001) and UNGASS (2001b).
[11] This working definition is drawn from the United Nations Development Programme's (UNDP, 1997) definition of human development and authors such as Fainstein (2000), Friedmann (1992), Healey (1996) and Smith (1994), amongst others.
[12] Positive developments include, inter alia, a reduction in infant mortality rates and the narrowing of the gender gap in education and health in certain regions (Browne, 2001).
[13] This perspective is still dominant amongst many states and international organisations (Potter and Lloyd-Evans, 1998).
[14] "Embourgeoisement" refers to the expectation that the whole society would become middle class once the benefits of economic growth would filter down to every one.
[15] In this context, the United Nations Development Programme (UNDP) refers to human development as a process of enlarging people's choices, the most critical ones being an ability to enjoy a long and healthy life, to acquire knowledge and to have access to resources needed for a decent standard of living (UNDP, 1997, p. 13). UNDP has developed the Human Development Index (HDI) in an attempt to broaden the economic interpretation of development by including some social indicators. The HDI is a composite indicator of life expectancy at birth, adult literacy rate, mean years of schooling and an adjusted measure of per capita economic production.
[16] In the foreseeable future, Gleeson and Low (2000, p. 8-9) predict a shift from a '20:80 society', where 20% of the population lives a comfortable and economically stable life whereas 80% with little to no job security lives on the verge of poverty, to a society where the ratio is 10:90 or even more disparate.
[17] This is not to suggest that cultural diversity in cities in developing countries is a new phenomenon, or that in the past they have been able to address cultural diversity (see, amongst others, Stren and Polèse, 2000).
[18] Some of the risks associated with environmental hazards include illness, unforeseen expenditure on health care and transport, loss of livelihood because of illness or death, reduced nutrition, psychological burdens in case of illness or death and a reduced sense of well-being and belonging, all of which leads to and aggravates impoverishment (Satterthwaite, 1999).
[19] The five formations of residential and business cities are: 1. the luxury city and the controlling city; 2. the gentrified city and the city of advanced services; 3. the suburban city and the city of direct production; 4. the tenement city and the city of unskilled work; 5. the abandoned city and the residual city.
[20] See, for example, the World Bank (2000).
[21] See, amongst others, the case of Porto Alegre as described by Abers (1998).
[22] This principle is a refinement of Fainstein's principle of material equality.
[23] This principle is a modification of Fainstein's principle of social diversity.

[24] This principle corresponds with Fainstein's principle of democracy.
[25] Fainstein's principle of environmental sustainability resonates with this principle, but is in my view not specific enough.
[26] According to a World Bank study, there are four times as many poor people as non-poor people in sub-Saharan Africa (quoted in Collins and Rau, 2000, p. 6).
[27] The past few months have seen significant changes, as some pharmaceutical transnational corporations have reduced the cost of patented drugs to African states in the face of mounting international pressure on pharmaceutical corporations and their host countries (in particular the United States). The recent court case in South Africa, initiated by the pharmaceutical corporations against the government in defence of patenting rights, proved a watershed in this regard. See, amongst others, Nevill (2001).
[28] For a more detailed discussion of this topic, see Baylies (2000b).
[29] I am aware that the use of race as an analytical category is controversial and that there is no scientific validity to use race as a distinguishing factor. However, in certain contexts, like South Africa, race has been an important signifier of group identity and will remain a very significant aspect of collective group identity given its socio-economic and political foundations.
[30] For example, evidence suggests that male circumcision significantly reduces the probability of HIV infection (UNAIDS, 1999).
[31] This includes access to treatment for sexually transmitted infections, access to condoms and information regarding the risks of HIV infection.
[32] Young women and girls are particularly at risk, as they have limited bargaining power and may engage in sexual activities in exchange for economic support. As CIRR (1999, p. 18) notes, sex between young girls and older men has been well-documented in Southern Africa. In some regions, it is believed that sex with a virgin girl can cure AIDS (Ibid).
[33] It is not necessarily the migration patterns of poor, young adults that put them (and their partners) at risk of infection. Relatively mobile groups, such as truck drivers, members of the armed forces or business men, who are HIV-positive can introduce HIV/AIDS into resident populations.
[34] Other factors, such as armed conflict and natural disasters, also create contexts of enhanced vulnerability to HIV/AIDS (Collins and Rau, 2000). They induce poverty and inequality and cause populations to be on the move. Rape and sexual slavery are often used as weapons of war.
[35] These groups are in addition to those traditionally characterised as 'high risk groups', such as prostitutes, homosexuals and drug users.
[36] Despite the prospect that unequal and fragile social relations may be put under further strain by the HIV/AIDS epidemic, a more optimistic view holds that ultimately social cohesion may be strengthened rather than weakened as people mobilise to respond to the crisis (UNDP, 2001).
[37] Child mortality is likely to increase either through mother-to-child transmission (MTCT) or through malnourishment and abandonment of orphans (Hope, 1999; Panos, 1992).
[38] It is suggested that fertility could either decrease, as people realise the danger of unprotected sex, or could increase, as a survival strategy in the face of higher risk of child mortality (Panos, 1992; Carballo and Carael, 1988).
[39] Carballo and Carael (1988) suggest that cities can either be perceived as risky places, where the threat of AIDS is particularly great, or as places with better health care and social services. Moreover, they raise the question whether migrants from rural areas return to these areas once they fall ill. Anecdotal evidence from South Africa suggests that HIV-positive migrants from Zimbabwe return to their families once they fall ill, but tend to come back to Johannesburg once they have recovered and often die there (personal correspondence with Hein Marais, UNAIDS, 4 May 2001).
[40] In the literature, orphanhood is generally defined as having lost either the mother or both parents.
[41] Orphans also risk having shorter life prospects. For example, in South Africa it is estimated that the death rate of orphans is three times higher than that of non-orphans (Department of Social Development, 2000).
[42] Although not reflected in the literature, it is likely that the psychological strain on all those somehow affected by HIV/AIDS will reduce their productive capacity.
[43] According to a study of 15 countries by the International Labour Organisation, by 2020 there would be 24 million fewer people in the workforce as a result of HIV/AIDS (UNAIDS, 2001c, p. 9).
[44] This is evidenced by the inability of democratically elected governments in developing countries to successfully incorporate HIV/AIDS into its policy concerns. The case of South Africa, which supports the notion of a representative democracy embedded within a participatory democracy, is a clear example.

[45] The initial epidemic, virtually restricted to the white gay male community, corresponded with the epidemic that took hold elsewhere in the developed world. The second epidemic, which was heterosexually transmitted, was consistent with the epidemic that surfaced in many other countries in sub-Saharan Africa in the 1980s (Van der Vliet, 2001). In July 1991, an equal number of homosexually and heterosexually transmitted cases of HIV infection was recorded (Whiteside and Sunter, 2000, p. 47).
[46] Not adding up to 100% stems from the fact that the Department of Health (2000) uses fairly loose data.
[47] This means that almost every minute, one South African becomes infected with HIV.
[48] In 1999, the following rate of HIV prevalence was recorded amongst women attending antenatal clinics: 15-19 (16.5%), 20-24 (25.6%), 25-29 (26.4%), 30-34 (21.7%), 35-39 (16.3%) and 40-44 (12%) (Department of Health, 2000, p. 4). A breakdown of male HIV prevalence by age group is not available.
[49] Although no data is available that indicates to what extent HIV/AIDS is associated with inequality and poverty, there is general recognition that poverty and inequality enhance vulnerability to HIV infection and that HIV/AIDS, in turn, intensifies inequality and poverty (UNDP-SA, 1998; Whiteside and Sunter, 2000). For a discussion on health disparities and HIV/AIDS, see Abdool Karim (1998), Department of Social Development (2000) and Tallis (1998).
[50] Currently, more women are HIV-positive than men and the trend for women to outnumber men amongst HIV-positive people is continuing (Whiteside and Sunter, 2000). According to studies conducted in KwaZulu-Natal, HIV is about four times more common among young women compared to men (Abdool Karim, 1998, p. 17).
[51] No comparative data is available regarding the marital status of HIV-positive women in South Africa. It is, however, recognised that increasingly monogamous women get infected because of their partner's risky (and socially condoned) sexual behaviour (Abdool Karim, 1998).
[52] Whereas the classification according to racial categories is not uncontroversial, it is commonplace in South Africa to use the four categories (African, Coloured, Indian/Asian, White) since they have become closely associated with material and political realities.
[53] This image of South Africa as the Rainbow Nation was projected most effectively by Archbishop Desmond Tutu in the mid 1990s to reflect a future of inter-racial harmony (Lester, Nel and Binns, 2000, p. 246).
[54] It has been reported that 98% of South Africans know HIV/AIDS is sexually transmitted and incurable (Marais, 2000, p. 47).
[55] Historically, socio-economic data in South Africa has not always been accurate. At times, data was deliberately manipulated by the apartheid government and as a consequence, many data has been contested.
[56] From an ideological perspective, the use of antenatal data as a way of statistical profiling has been criticised for making men invisible and contributing to a perception that women as carriers of the disease are responsible for the infection of others (Tallis, 1998).
[57] For a categorisation of urban areas in South Africa, see Ministry for Provincial Affairs and Constitutional Development, 1998, pp. 27-28.
[58] This is compounded by the fact that the epidemic is occurring at a time when South Africa is already facing a skills shortage (Whiteside and Sunter, 2000).
[59] A more in-depth discussion of the political controversies surrounding HIV/AIDS in South Africa is provided in Marais (2000) and Van der Vliet (2001).
[60] The Gini Index is a commonly used measurement of inequality within a country.
[61] The term 'black' here refers to population groups classified as African, Coloured and Indian/Asian.
[62] This figure correlates with $2.00 per day, based on the 1998 exchange rate of R 1.00 valued at $ 0.18 (SAIRR, 1999, p. 430).
[63] The distinction between a strict and expanded definition lies in the criterion that those qualifying as unemployed must have actively sought work in the preceding month (SAIRR, 1999, pp. 299-300).
[64] There is no further breakdown of the urban unemployment rate based on sex. Only national unemployment data by race is further disaggregated by sex. Based on the expanded definition of unemployment, unemployment by race and sex is as follows: African women (52%), African men (34%), Coloured women (24%), Coloured men (18%), Indian women (14%), Indian men (11%), White women (5%), White men (4%) (SAIRR, 1999, p. 301).
[65] In 1995, economic growth was 3.5%, compared to 1.5% in 1997 and 0.5% in 1998 (Department of Social Development, 2000, p. 20)

[66] The State of South Africa's Population Report (2000) presents statistics reflecting that most job losses have occurred in manufacturing (94 900 jobs between 1994-1997), building and construction (51 400 jobs between 1994-1997) textile (20 000 jobs between 1997-1998), with a total job loss in the formal non-agricultural sector of 250 000 jobs between 1994-1999 (Ibid, p. 9).
[67] The male/female distribution of the population in the four most urbanised provinces and North West show a disproportionate (i.e. over 48%, as this is the national proportion of men of the whole population) presence of men, with Gauteng being the only province where men outnumber women (SAIRR, 1999, p. 20).
[68] Between 1992 and 1996, Gauteng, the most urbanised province in the country, received 262 000 migrants and the Western Cape about 150 000. Rural provinces lost people through out-migration, with the Eastern Cape (over 200 000) and Northern Province (about 140 000) recording the highest net loss (Department of Social Development, 2000, p. 19).
[69] The WPLG also addresses the role, responsibilities and system of rural local government. Moreover, it touches on intergovernmental relations, thereby emphasising that urban/rural development is not only the responsibility of local government.
[70] Other reasons include the fact that HIV/AIDS is politically sensitive and that it started to take on epidemic proportions during a period characterised by the complexity of political transition and institutional transformation. In a context of competing priorities and restricted public sector capacity, the invisibility of AIDS allowed (and continues to allow) policy makers to ignore its gravity.
[71] Developmental local government is defined as "local government committed to working with citizens and groups within the community to find sustainable ways to meet their social, economic and material needs and improve the quality of their lives" (Ministry for Provincial Affairs and Constitutional Development, 1998, p. 31).
[72] The survey included City of Cape Town, Durban Metropolitan Council, Greater Johannesburg Metropolitan Council and Port Elizabeth.
[73] A scan of information and documents on their websites showed that there is no mention of HIV/AIDS whatsoever.
[74] Because visions reflect ideal images of the future, they are likely to be the object of critique. This is also the case with the UDF's 'urban vision 2020', which has been criticised by Mabin (2000) for lacking specificity and not resonating with reality.