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1. THE GLOBAL PICTURE

Globally Sub-Saharan Africa stands out as the area in the world most severely infected by AIDS. In summary the 1998 picture was estimated to be as follows:

Sub-Saharan Africa	20 800 000 people	(68%)
Southeast Asia	6 000 000 people	(20%)
Rest of the world	3 812 000 people	(12%)
Total in 1998	30 612 000	

South Africa is, furthermore, described as the country where AIDS infections are growing the fastest in the world (Carol Coombe, June 2000).

2. THE NATIONAL PICTURE

The prevalence rate of AIDS, measured on the basis of women attending antenatal clinics, in the Western Cape is presently the lowest of all provinces in SA, KwaZulu-Natal being the highest.

Table 1: AIDS PREVALENCE IN THE WESTERN CAPE KZ-NATAL AND THE RSA (%)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Western Cape	-	-	-	-	1.2	1.7	3.1	6.3	5.2	7.1
KZ-Natal	1.6	2.9	4.8	9.6	14.4	18.2	19.9	26.9	32.5	32.5
South Africa	0.8	1.4	2.4	4.3	7.6	10.4	14.2	17	22.8	22.4

Source: Alan Whiteside and Clem Sunter: AIDS: the Challenge for South Africa, 2000

From the above table it is clear that the rate of increase in the Western Cape is rising and that its present prevalence is comparable to that in KwaZulu-Natal about 6 or 7 years earlier and some 5 years ago in SA as a whole. The rate of increase in AIDS infections between 1998 and 1999 was 36,5% in the Western Cape, the highest of all provinces (Dept. of Health, 2000).

It has been observed that the level of infection tends to stabilise around 30%. This may mean that infections will reach that level in the Western Cape in 6 or 7 years from now, but it has also been argued that a lower peak will be reached in the Western Cape due to general advances in prevention in South Africa. In his projections for the CMA, Dorrington expects the prevalence level for the Metropolitan Area to plateau at about half the level of the national population.

3. POTENTIAL IMPACTS

The concern of the Provincial Housing Plan has more to do with the demographic impact of AIDS and the resultant impact on housing demand in terms of numbers and types of dwellings in particular. However, it is important to note the broader context of the impact of AIDS. This is well illustrated by Whiteside and Sunter in their book *AIDS: The Challenge for South Africa*. They point out that AIDS will have both social and economic effects, because the individual is:

- A consumer:
  - a purchaser of goods and services
  - has an influence on the market
  - is a user of health and welfare services
- A producer:
  - a producer of labour
  - a producer of savings and investment
- A family member:
  - an income earner
  - a caregiver
  - an educator
- A community member:
  - a community service provider
  - a leader
  - a community supporter

Illness or deaths of individuals will, therefore, impact at all these levels.

3.1 The potential **demographic impact** of AIDS is described as 'dramatic and dynamic', should present trends continue. Most people are infected in their late teens and early 20's and are expected to die in their late 20's and early 30's. Because of the fact that this normally represents the most fertile age group, the impact on the number of children born to the population as a whole is expected to be severe. Also, children born from infected mothers stand a good chance (about 30%) of being infected at birth and infected children will, almost without exception, die within five years ***[Konrad Adenauer Stiftung: Occasional Papers, June 2000].***

3.2 If present trends continue, it is estimated that the annual **number of deaths** due to AIDS will be equal to the number of normal deaths in SA by the year 2006, namely about 450 000. Dorrington expects that, in the Cape Town Metropolitan Area, this level will be reached by 2009 when AIDS will account for about 29 000 deaths per year in the CMA. An estimate of deaths due to AIDS ia set out in the next table.

3.3 In 1998 the **child mortality rate** in SA was 96 per 1000 births. It would have been 70 per 1000 without AIDS. This is estimated to increase to 100 per 1000 in 2010, whilst it would have decreased to 49 per 1000 without AIDS.

3.4 **Life expectancy** in SA increased steadily up to a level of 64 years and then started to decline due to AIDS. According to projections up to the year 2010, life expectancy will then be down to 48 years. Dorrington projects the life expectancy of the Coloured population to drop from 65 years to 55 years within the next 10 years and that of the Black population from 55 to about 40 for the CMA.

3.5 Due to the fact that deaths of young adults will more or less be balanced by child deaths, **dependency ratios** are not expected to be affected much, statistically. The fact that AIDS deaths will lead to an increase in the number of widows and orphans, will, however,

adversely affect the real dependency situation. It has been estimated that the number of AIDS orphans (defined as children under the age of 15 who have lost at least a mother) will rise to 1 million by 2005 and to 2 million by 2010 in SA. It has been estimated that there will be a total of 1 000 000 AIDS orphans in South Africa by the year 2006. If it is assumed that the geographical distribution of such orphans will be proportional to the geographical distribution of HIV / AIDS infections, then the proportion of orphans that is likely to be in the Western Cape Province, may be calculated on the following basis:

By 2006 the total population of the Western Cape may be about 10% of the national population and the level of HIV infections in the Western Cape may be equal to 50% of the national rate (Dorrington, with respect to the CMA). Therefore the number of AIDS orphans may be 1 000 000 x 10% x 50% = 50 000, say between 40 000 and 60 000. Many of these orphans are likely to be accommodated by relatives and friends, but many of them will be homeless unless they are provided for by the state or welfare organisations.

3.6 As has been mentioned in 3.1 above, more people in the 20 to 40 age groups are expected to be infected. People in these age groups are caring for many elderly people. The result will be that care for the aged might become more problematic.

3.7 It is also estimated that **more women than men** are infected by the HIV virus, which means that the gender ratios will eventually be skewed. Presently the number of infected people in SA is estimated to be made up of 56% women, 40% men and 4% babies.

3.8 Nationally, the effect of AIDS on the **population growth rate** will be significant: it is expected that the growth rate will fall below 1% in 2004 and will reach 0% in 2011 at a total population figure of about 49 million, as opposed to 61 million without AIDS. This represents a 19% reduction in the projection without the influence of AIDS ***[Konrad Adenauer Stiftung: Occasional Papers, June 2000].*** In the Western Cape Province the largest contributor to population growth is presently represented by in-migration from the rest of country. The numbers of migrants are however expected to decrease substantially over the coming years. AIDS deaths, on the other hand, are expected to increase dramatically over the same period, to the extent that by 2005 it is estimated that it will nullify the effect of in-migration. These estimates are shown in the next table.

Table 2: ESTIMATES OF IN-MIGRATION AND AIDS DEATHS IN THE WESTERN CAPE PROVINCE

YEAR	IN-MIGRATION	AIDS DEATHS
2000	43 600	6 800
2001	40 800	8 700
2002	38 000	11 500
2003	35 200	15 400
2004	32 400	20 000
2005	28 600	26 800
2006	24 800	32 300

3.9 It is clear that AIDS also has the potential to impact negatively on **poverty**, e.g. loss of income due to illness or death and due to medical expenses. It has been projected that AIDS will infect more than a third of semi- and unskilled workers by 2005, compared with 23% skilled and 13% highly skilled workers.

3.10 **The State's ability** to provide for the poor may, furthermore, be affected as its responsibilities in the field of medical care rise.

4. POSSIBLE IMPACTS ON HOUSING

The impact of AIDS on housing is clearly a complex issue. When calculating the demand for housing, it will be a gross simplification to merely divide the number of deaths by an assumed household size in order to get an indication of lower demand. The number of households will not decrease in proportion to the number of AIDS deaths since only one or two members of many households may die. It should however be accepted that the likelihood of both parents in a household being infected by AIDS would be relatively high.

Apart from a resulting lower demand in the number of houses, the most serious impacts of AIDS on households are likely to be:

- Illness, with all its consequences, not the least of which will be financial: particularly medical expenses and loss of income;
- An increase in single parent households, also taking into account that more female than male deaths are likely to occur, resulting in more single male headed households;
- An increase in the number of orphans;
- An increase in the number of smaller households on the one hand, but insofar as relatives and friends will absorb members of households that are affected by AIDS (orphans in particular), there may also be an increase in the number of larger households;
- An increase in children headed households;
- An increase in the number of dependent elderly people.

All the above may have housing consequences that are in large part related to variations in the type of accommodation that will be required rather than to demand than can be expressed in mere numbers.

In this regard Whiteside and Sunter (p. 91) point out that the present design of homes may not be appropriate for a population facing an AIDS epidemic and mentions that the KwaZulu-Natal Provincial Housing and Development Board issued a guideline, *AIDS: Provision of Housing*. In this document it is pointed out that the Housing Act No 107 of 1997 calls for all levels of government to '*promote the meeting of special housing needs, including, but not limited to, the needs of the disabled'*.

Consideration will, amongst others, have to be given to the following:

- More orphanages;
- Special types of accommodation for orphans, such as cluster homes;
- Increased free medical care;
- Transitional housing for destitute adults and children;
- Provision for home-based care;
- The empowerment of neighbours and family to care for AIDS patients;
- More community crèches and day care centres;
- More homes for the aged or home based care for them.

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