CONCEPTUALISING HOUSING AS A PROBLEM FOR POOR PEOPLE LIVING WITH HIV/AIDS IN BOTSWANA: A CASE STUDY OF GABORONE

By

Kelebogile Kgosi

A thesis submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy

School of City and Regional Planning

Cardiff University

October 2010

Form: PGR_Submission_200701

NOTICE OF SUBMISSION OF THESIS FORM: POSTGRADUATE RESEARCH

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

NOTICE OF SUBMISSION OF THESIS: POSTGRADUATE RESEARCH DEGREES
Please TYPE or write in BLACK ink and use BLOCK capitals

SECTION A: TO BE COMPLETED BY THE CANDIDATE AND SUBMITTED WITH THE THESIS

CANDIDATE'S LAST NAME	KGOSI
CANDIDATE'S FIRST NAME(S)	KELEBOGILE
CANDIDATE'S ID NUMBER	0637530
SCHOOL	CITY AND REGIONAL PLANNING
TITLE OF DEGREE	Please circle appropriate degree title EdD, EngD, DSW, DClinPsy, DHS, MCh, MD, MPhil, MScD by Research, PhD
FULL TITLE OF THESIS	CONCEPTUALISING HOUSING AS A PROBLEM FOR POOR PEOPLE LIVING WITH HIV/AIDS IN BOTSWANA: A CASE STUDY OF GABORONE
IS THIS A RESUBMISSION?	NO
THESIS SUBMITTED FOR EXAMINATION IN	Permanent Binding ☑
FULL ADDRESS FOR RECEIPT OF RESULT LETTER, DEGREE CERTIFICATE AND DETAILS OF THE GRADUATION CEREMONY	**P.O. Box 70410** **UB POST OFFICE** **GABORONE** **BOTSWANA** **You must notify Cardiff University immediately if this address changes via:** postgraduate@cardiff.ac.uk

DO YOU WISH TO ATTEND THE DEGREE CEREMONY	**YES**
CONTACT TELEPHONE (WITH DIALLING CODE)	**00267 73760293**

EMAIL ADDRESS	**kgosik@mopipi.ub.bw OR ntukekgosi@hotmail.com**		
CANDIDATE SIGNATURE		DATE	**05 August 2011**

POSTGRADUATE RESEARCH

UNIVERSITY
PRIFYSGOL
CAERDYDD

DECLARATION

This work has not previously been accepted in substance for any degree and is not concurrently submitted in candidature of any degree.

Signed..... (candidate) Date....10.08.2011

STATEMENT 1

This thesis is being submitted in partial fulfilment of the requirements of the degree of PhD.

Signed..... (candidate) Date....10.08.2011

STATEMENT 2

This thesis is a result of my own independent work/investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references.

Signed..... (candidate) Date....10.08.2011

STATEMENT 3

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title summary to be made available to outside organisations

Signed..... (candidate) Date....10.08.2011

STATEMENT 4: PREVIOUSLY APPROVED BAR ON ACCESS

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loans after expiry of a bar on access previously approved by the Graduate Development Committee.

Signed ..... (candidate) Date 10.08.2011

ABSTRACT

This study explores the housing related problems and constraints faced by poor people living with HIV/AIDS in Gaborone. The study concurrently examines the housing interventions provided by the different housing providers, particularly looking into the availability, accessibility and affordability of the housing-related services in the form suitable for PPLWHA. Housing is one of the largest unmet needs among the poor people living with HIV/AIDS in Gaborone although it is a basic need. The lack of sanitary and stable housing has been key in housing and HIV/AIDS debates around the world and has been attributed with profound effects on the management of HIV/AIDS among PPLWHA.

The study hinges on critical realism theory and posits that the housing problems faced by PPLWHA are not an outcome of a single cause but of a web of interacting and interconnected, social, economic, political and environmental factors apparent in Botswana.

A qualitative semi-structured strategy through in-depth interviews is used in this study to explore the following: firstly, the housing problems and constraints faced by PPLWHA as well as the strategies they adopt to respond to these problems. Secondly, to gain perspectives of lands and housing policy makers as well as personnel offering housing and housing related services who were interviewed to provide a picture of the implementation of policies, programs and services intended to respond to the housing for poor people. The major conclusion of the thesis is that poverty and HIV/AIDS are interconnected and primary in the everyday life of PPLWHA, and limit their opportunity to afford and access sanitary housing. Consequently they are limited to inhabit poor and unsanitary housing environments in informal housing markets which make it difficult for them to manage their health. The study argues that the housing problems faced by PPLWHA go beyond the observable conditions of poverty and HIV/AIDS. There are other underlying structural barriers, observable and non-observable, which contribute to the housing problems faced by PPLWHA. Firstly, the lack of sanitary and affordable housing, which incorporates the issue of housing finance which is suitable for those on a low income and the poor. Secondly, limited governmental support in the regulation and control of the informal housing market for low income people, thirdly the lack of collaboration of housing organisations aimed at housing the poor and vulnerable people in the country and fourthly

the social structures such as cultural norms and traditional beliefs and gender inequalities which are interconnected with HIV/AIDS and poverty which exacerbate housing problems of PPLWHA. This study recommends that if Botswana is to tackle the spread and treatment of HIV and AIDS in society, the lack of adequate housing must be addressed as a barrier to effective HIV prevention, management and care. It is crucial to address the need for stable housing for people with HIV and AIDS.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGEMENTS

Eternal thanks to Almighty God. Through His Grace this work was possible.

Nothing in life is ever successful without the corporate effort of many gifted people who are willing to network and submit their talents, experience and passion for a common goal. We are the sum total of all the people we have met and learned from. This work is a product of countless individuals whose ideas, perspectives, thoughts and work have given me the opportunity to access the knowledge I have included in this thesis.

This doctoral thesis would not have been possible had the School of City and Regional Planning at Cardiff University and the University of Botswana not provided me with the opportunity and support over the duration of my study.

The thesis has been completed with the unlimited advice, guidance, mentorship and encouragement from my Supervisors: Dr Craig Gurney and Mr Neil Thomas. My gratitude to Professor David Clapham and Ms Alison Brown who were my supervisory panel members, for their valuable guidance, support and time in this research.

I am greatly indebted to the people living with HIV/AIDS in these Support Groups: BONEPWA, CEYOHO, Matlo go sha mabapi, Nkaikela and Hanna House of Hope and all the PPLWHA who gave up their time to take part in this research.

I have made many friends and have been fortunate to enjoy the unwavering support from many of the staff and postgraduates students in CPLAN. Particular thanks must go to Nezar Kafafy and Syafiee Shuid whom I shared moments of frustrations and their encouragement and mutual support has seen us through.

I cannot conclude these acknowledgements without special thanks to my family: my husband Shadreck for his love, patience, valuable support and for raising our sons single-handedly and patiently during my absence from home. A big thank you to my two beloved sons; Karabo and Leungo, for their patience, support and motivation for they were a continued reminder that I must finish my studies and come back home.

To my lovely mother, Mma Sethunya, who has been a star in my life; my sisters and brother; my extended family members and friends in the UK and Botswana, thank you all ever so much for your support.

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome or Acquired Immunodeficiency Syndrome
ALSP	Accelerated Land Servicing Programme
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BBS	Botswana Building Society
BHC	Botswana Housing Corporation
BML	Building Material Loan
BONELA	Botswana Network on Ethics, Law and HIV/AIDS
BONEPWA	Botswana Network of People Living With HIV and AIDS
CBO	Community Based Organisation
CEYOHO	Centre for Youth of Hope
COR	Certificate of Rights
DoH	Department of Housing
DoL	Department of Lands
DoSS	Department of Social Services
FAO	Food and Agricultural Organisation
FPSG	Fixed Period State Grant
GCC	Gaborone City Council
GoB	Government of Botswana
HAART	Highly Active Anti-Retroviral Therapy
HFH	Habitat for Humanity
HFHB	Habitat for Humanity Botswana
HIV	Human Immunodeficiency Virus

MPR	Medical Priority Rehousing
NACA	National AIDS Coordinating Agency
NGO	Non Governmental Organisation
OVC	Orphans and Vulnerable Children
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of mother to child transmission
PPLWHA	Poor People Living with HIV and AIDS
SADC	Southern African Development Community
SHHA	Self-Help Housing Agency
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNCHS	United Nations Centre for Human Settlements (Habitat)
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

> "Housing forms an indispensable part of ensuring human dignity. Adequate housing encompasses more than just the four walls of a room and a roof over one's head. Housing is essential for normal healthy living. It fulfils deep-seated psychological needs for privacy and personal space; physical needs for security and protection from severe weather; and social needs for basic gathering points where important relationships are forged and nurtured. In many societies, a house also serves an important function as an economic centre where essential commercial activities are performed." (International Human Rights Internship Program, 2000:1).

1.1 Preamble

Housing conditions are important for the wellbeing of all people. In many developing countries housing is one of the major challenges facing urban dwellers as well as housing policy makers (Kumar, 1996; Precht, 2005). Forty four years after independence, the provision of housing in Botswana is still inadequate in quality and quantity. This problem is particularly evident in urban areas such as Gaborone, where affordable housing for low income people is in short supply (Ikgopoleng and Cavric, 2007). The housing shortage problem is acute among the poor people. The extensive spread of HIV/AIDS in Botswana has also increased the housing problem in the country. With an estimated 23.9% prevalence rate among adults aged between 15 and 49 (UNAIDS, 2010), the epidemic has placed many families into poverty consequently making it difficult for them to afford housing. Faced with the lack of affordable formal housing solutions coupled with the inability to pay for decent housing, Poor People Living with HIV/AIDS (PPLWHA) usually resort to living in sub-standard housing in unregulated informal settlements. The housing quality in these areas is usually poor and has a negative impact in the already compromised health of Poor People Living with HIV/AIDS.

The shortage of decent, affordable and sanitary housing for the low income people could be attributed to a combination of issues in the housing market coupled with policy constraints which consequently impact on the housing supply and demand (Omar, 2003). Having a secure and appropriate place to live is affected by many factors within the

existing stock of affordable housing, including the political, economical, credit and other policies and institutional practices that shape the availability of housing to the general population. The failure of formal public and private organisations to satisfy the housing demand coupled with the inadequacy of financial loans for constructing safe and sanitary housing, which meets the stipulated urban standards, has increased the problem of supply of low income housing for low income people. This has led to pressure on alternative forms of housing tenure, particularly informal renting and house sharing. Furthermore, it has created a niche in the low income housing market which as a result encourages informal landlords to sublet housing to many households consequently creating overcrowding and unhealthy housing conditions which are unsuitable for the improvement in health particularly for PPLWHA. The inability of households and individuals affected by HIV/AIDS to afford adequate shelter and related services including water, sanitation and waste removal in particular requires government intervention. This could be achieved through making housing a priority in fighting the HIV/AIDS epidemic. Improved access and availability of good affordable housing and related housing services have the potential to help PPLWHA reduce being exposed to factors that exacerbate their health as well as putting other people at a risk of contracting HIV/AIDS and related communicable illnesses.

1.2 Statement of the problem

In 2007, UNAIDS reported an estimated total of 300,000 people living with HIV with a prevalence rate of 23.9% among adults aged between 15 and 49 in Botswana, a country of population of less than two million people. This indicated that the epidemic has clearly reached crisis proportions in Botswana.

While HIV infection is increasingly characterised as a chronic condition, it can be managed through adherence to a healthy lifestyle (Aidala et al, 2007). Living with HIV/AIDS demands that the patient comply with the drug routine which includes, having adequate rest, maintaining good nutrition and receiving regular treatment and monitoring by health care and social support professionals (Leaver et al, 2007). For many PPLWHA, the location, quality and/or affordability of a person's housing can be a significant factor of his or her ability to meet these needs. However, the inequality between sustained stable housing and PPLWHA's needs is made more difficult by the fact that living with HIV/AIDS often places a significant strain on the individual's resources and reduces their

capacity to maintain employment and socially integrated lifestyles, particularly for those who regularly suffer from HIV related opportunistic illnesses.

As a primary facet of everyday life, housing plays a fundamental role in determining the physical and social risk environment. Although research has shown that stable and good housing has a positive effect on health outcomes among persons living with HIV/AIDS (Aidala et al, 2007; Leaver, et al, 2007) these studies have been conducted in developed countries in the Global North with little attention paid to countries in the Global South. Despite the various countries of study, backgrounds and contexts, all these studies emphasise the importance of healthy housing as an intervention strategy in the fight against HIV/AIDS. For instance, in Canada, CAHM (2007) looked into making housing a priority for PPLWHA, in United States of America Aidala et al (2005) observed the relationship between housing status and HIV risk behaviours; while Elifson et al (2007) discussed the impact of unstable housing on HIV/AIDS reduction; in South Africa, Tomlinson (2001) analysed the housing policy in the context of HIV/AIDS.

However, Botswana lacks disaggregated data as well as documentation and information focused on the relationship between housing and HIV/AIDS. There has been little published academic research focused on the area of housing in relation to HIV/AIDS in Botswana. Studies that have been done have considered the two issues in isolation. For instance, on one hand there are official evaluations of housing programmes for the poor such as Self Help Housing Agency (Government of Botswana, 1982 and 1992; Ikgopoleng and Cavric, 2007) and the National Housing Policy Review (Government of Botswana, 2000) which nevertheless overlooked HIV/AIDS as a housing problem. On the other hand, studies which looked into HIV/AIDS have focused more on the consequences of the epidemic either on the epidemiological and demographic repercussions of the disease (UNDP, 2000); the disease's influence on key macroeconomic variables and household incomes; or its effect on government revenues (Botswana Institute for Development Policy Analysis, 2000; National AIDS Coordinating Agency, 2006). This is despite the assumption that generally in Botswana, and especially in Gaborone, poor people living with HIV/AIDS are faced with various housing problems including living in poor housing conditions which contributes negatively to their already poor health.

In supposition, the reason why there is such little research in the area of housing and HIV/AIDS in Botswana is primarily because Botswana is a relatively small developing

country with a population of fewer than two million people, therefore there are relatively few academics involved in housing research. The assumption is that this study will fill in the gap in housing and HIV/AIDS research profile in the context of Botswana, particularly that no work of this nature has been conducted previously in the country.

Drawing on critical realism, this thesis will explore the underlying structures and conditions that contribute to the housing problems faced by PPLWHA hence providing useful insights into housing problems faced by PPLWHA in Gaborone. The goal is that by so doing the study will integrate interdisciplinary contributions for better understanding and informing of the housing practice and policy development consequently improving the overall housing and health outcomes of PPLWHA.

Furthermore, the hope is that through this study, the researcher will become an attuned professional with an enhanced personal foundation in housing and HIV/AIDS.

1.3 Aims of the study

The primary aims of this research are twofold: firstly, to explore housing related problems and constraints faced by the poor people directly affected[1] by HIV/AIDS as well as their response to the difficulties and problems at individual and family level; secondly, to analyse the intervention mechanisms planned and implemented through the national housing policy and by other housing and related stake-holders in response to the difficulties faced by PPLWHA in housing.

1.4 Key research questions

The key research questions to be addressed by this thesis are:

1. What are the socio-economic, environmental, and physical and health problems and difficulties experienced by the poor people living with HIV/AIDS in their housing in Gaborone?

[1] For the purpose of this study, people who are directly affected by HIV/AIDS refer to those that are infected by HIV, AIDS patients and their immediate family members; emphasis is on the poor people living with HIV/AIDS.

2. How do the poor people living with HIV/AIDS respond in an endeavour to cope with their housing problems and difficulties?
3. What underlying factors and/or structures are apparent to the different housing stakeholders; hence having an influence in the response to the housing problems and difficulties faced by PPLWHA?
4. What intervention strategies have the lands and housing policy makers and other housing stakeholders put in place in response to lands and housing problems and difficulties faced by poor people living with HIV/AIDS?

In order to understand the context in which this study took place, it is important to briefly discuss the profile of the case study area, Gaborone City.

1.5 Gaborone: the case study area

For eighty years since 1885 when Botswana was a British Protectorate, the country was known as Bechuanaland. It attained self governance in 1965 and was renamed The Republic of Botswana (commonly known as Botswana) after independence in September 30th, 1966. Botswana is a landlocked semi arid country with a mean altitude above sea level of approximately 1000 metres. It is approximately 582 000 square kilometres and is about the size of France. It lies at the centre of the Southern African plateau with the Tropic of Capricorn running through it. Botswana is bordered by South Africa to the South and South East, Zimbabwe and Zambia to the North East and Namibia to the North and West (Mathuba 2003; Government of Botswana, 1997). See Figure 1.1 overpage;

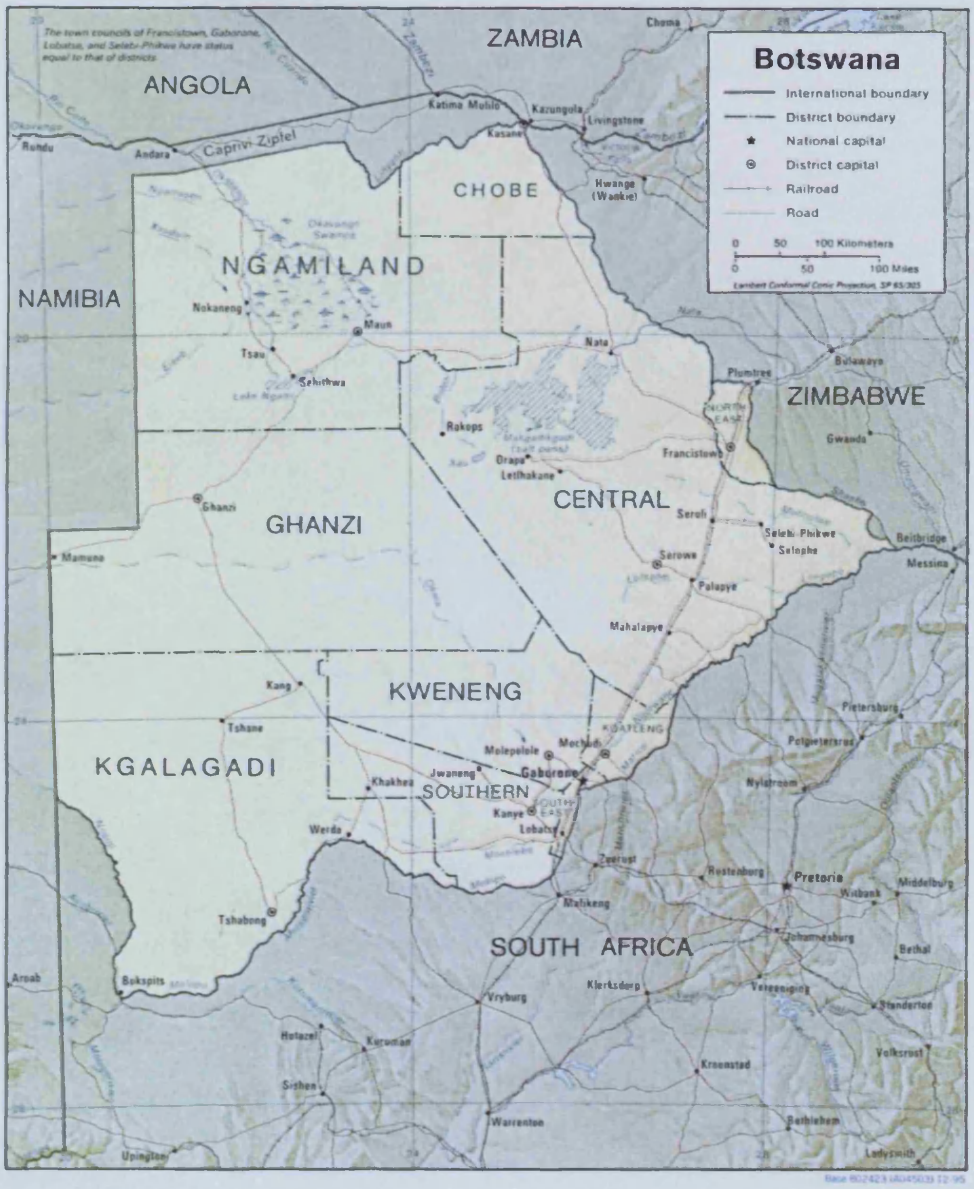

Figure 1.1: A regional map of Botswana.
Source: Botswana Government, Department of Tourism, 2006

Gaborone is the capital city of Botswana and has a population that has grown from 133,500 in 1991 to 224, 000 in 2001 (GoB 2002b). Gaborone replaced Mafeking as the capital of the Bechuanaland Protectorate in 1965. Mafeking (now Mafikeng) was outside the Bechuanaland Protectorate, in what is now the North West Province of South Africa, an odd arrangement that dated from the early colonial period. When the Bechuanaland Protectorate became independent, Botswana needed a capital city within its territory, hence Gaborone was established.

As an administrative, commercial and industrial hub of the country, Gaborone is growing very fast. This unprecedented economic and population growth has been accompanied by constraints such as the need for land, housing and increased demand for social and infrastructural services in the city. This has put a severe strain on the resources available to Gaborone City Council (GCC), which governs the city (Mosha, 2004). As Botswana is faced with the problem of HIV/AIDS, and studies reported poverty levels to be high (BIDPA, 2000) this researcher found it necessary, as already indicated, to explore the housing problems faced by people living with HIV/AIDS in Gaborone as well as analyse how the problem has been responded to by the housing policy makers and related stakeholders.

1.6 Structure of the thesis

The thesis is organised into seven chapters as follows:

Chapter 1, the current chapter states the issues and problems addressed by the thesis; its aims, objectives and justification. It then presents the key evidence about the nature and extent of HIV/AIDS in Botswana before proceeding to provide background to the nature of housing provision in Botswana as well as justification of choosing Gaborone as the case study.

Chapter 2 presents the conceptual framework of the study. The focus of this chapter is to explore the relationship between housing, health and HIV/AIDS as well as outline the importance of housing in health through a critical review of the literature linking the three concepts - housing, health and HIV/AIDS.

Chapter 3 is focused on providing a synoptic background to HIV/AIDS in Botswana. It proceed to giving a summary of housing provision in Botswana, discussing the contribution and role played by both the formal and informal housing market in provision of housing for the poor in general and PPLWHA especially.

In chapter 4, the theoretical perspective of critical realism is presented, giving an insight into the way in which the theoretical position influenced this study. The chapter proceeds to identify and justify the methodology and methods adopted in this study in the various research stages including data collection to data analysis.

Chapters 5 and 6 present the empirical findings of this research. Chapter 5 describes the results from the in-depth interviews with the PPLWHA presenting the problems they face in their housing. The impact of the housing problems faced by PPLWHA on their health condition is discussed in this chapter.

Chapter 6 presents the response from the interviews with the government and non-governmental organisations in Botswana in terms of housing problems faced by the PPLWHA. It then proceeds to analyse the housing policies and programmes aimed at the provision of housing for the poor particular emphasis given to how they integrate HIV/AIDS and to address in particular the housing needs of PPLWHA.

Chapter 7 summarises the study findings and draw conclusions arising from the discussions. It then proceeds to make recommendations on how this study can be used to stimulate future lines of inquiry within the housing policy, practice and research in Botswana.

CHAPTER 2: HOUSING, HEALTH AND HIV/AIDS

2.1 Introduction

This chapter presents the conceptual framework of the study. The focus of this chapter is to explore the relationship between housing, health and HIV/AIDS as well as outline the importance of housing in health through a critical review of the literature linking the three concepts - housing, health and HIV/AIDS.

Healthy housing, together with good sanitation, healthy food, clean water and clothing, is a basic human requirement (Ranson, 1991: viii). Increasingly, housing has been recognised as a fundamental determinant of health and a major public health issue (Dunn, 2002). Research has shown that good quality housing is associated with favourable health outcomes (Evans et al, 2003). Poor housing has been demonstrated to increase vulnerability to infection, exacerbate illness and is associated with increased need for health support (Ranson, 1991; CAHM, 2007). On the contrary, the opposite is true for good housing as it has the capacity to positively influence good health outcomes (Dunn, 2002). While many people in countries around the world are able to choose their housing in developed owner occupation and established rental markets, there are some who struggle to secure sanitary housing because of lack of income, vulnerability and incapacity. Consequently, they end up living in unsanitary housing conditions despite the association of poor housing with a wide range of health conditions. Among the population who live in poor housing conditions, are those who are not only poor but are in addition living with HIV/AIDS (PPLWHA). This is regardless of ongoing debates that have demonstrated that stable and sanitary housing has an increased potential to improve the quality of the life of a person battling with HIV/AIDS (Aidala et al, 2000).

> "A stable place to live does make it possible to begin to untie the knot challenges of life with HIV/AIDS; it offers a stable place to rest, to be safe, to receive regular therapies and a place to gather one's thoughts for the challenges ahead" (Cisneros 2007:1)

Research has outlined that housing provides a structure that directly or indirectly affects an individual's ability to avoid exposure to HIV or for PLWHA to avail themselves of health-promoting and risk-reducing resources (Aidala and Sumartojo, 2007). The purpose of this chapter is to direct attention to the crucial role of housing in shaping the health of people.

Particular emphasis will be on reviewing the literature that outlines the importance of housing as a means that has the potential to be used in fighting the HIV/AIDS epidemic.

The chapter will be divided into five sections for setting the study's context and focus. Each section will describe the problem, and draw from available literature from other researchers within the related area. Areas where important gaps in knowledge exist will be highlighted.

Section 2.1 gives the introduction and outlines the different sections of this chapter.

Section 2.2 defines the relationship of the two key words used in this chapter - housing and health putting them into context. It describes a perspective on why housing is important and what it means to provide good housing.

Section 2.3 discusses the health and housing linkage, emphasizing the crucial role played by housing in buffering from or exposing people to general health risks. The review of the existing evidence on housing and health and identification of the possible gaps in research on the role played by housing in the production of health inequalities will be considered in this section.

Section 2.4 will particularly discuss the relationship between housing and HIV/AIDS. The section will especially draw from studies that have been carried out to establish evidence that supports the contribution made by provision of housing in the fight against HIV/AIDS.

Finally, section 2.5 will offer some conclusion to what has been presented in the chapter.

2.2 Defining Housing and Health

> "Housing, as a central locus of everyday life patterns, is likely to be a crucial component in the ways in which socio economic factors shape health" (Dunn, 2003:1)

Housing is a crucial nexus for the operation of a wide range of socio-economic factors that fundamentally shape the character of everyday life for people across the socioeconomic spectrum. The importance of shelter is outlined in the Universal Declaration of Human Rights of 1948:

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services" (UN, 1948: Article 25(1).

Ranson (1991) defines housing as a medium through which health determinants operate, as well as one of a number of socio-economic factors that influence health. Housing is not taken to simply mean the physical structure of a dwelling that is concerned with the sanitary and hygienic design of the shelter, but encompasses the sanitary adequate shelter with the whole health spectrum of the physical, mental and social wellbeing both within the dwelling and the surrounding environment impacting upon the dwelling and its occupants. Fuller- Thomson et al (2000) argue that housing includes these four elements, each of which plays an important role in the quality of life and overall well-being of individuals and households: The house – the physical structure, its design and characteristics; the home – the social and psychological aspects of the house; the neighbourhood – the immediate physical area around the house and home; the community– the social characteristics and range of important services in a neighbourhood.

On the other hand, the definition of health has been outlined by the World Health Organisation's using this definition which is the most widely accepted:

> "A state of physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948).

Therefore, in a broader context, healthy housing is thus not just concerned with avoidance of disease and ill health but is about provision of a living environment for betterment of health.

According to The World Health Organization (WHO) Regional office for Europe quoted by Ranson (1991:1), 'healthy housing', is:

> "A human habitation that is structurally sound and relatively free from accidental injury hazards, provides sufficient space for all normal household activities for all members of the family, has readily and easily available an adequate supply of potable and palatable water, has sanitary means of collection, storage and disposal of all liquid and solid wastes, is provided with appropriate installed facilities for personal and household hygiene and cleanliness, is sufficiently weatherproof and watertight, provides proper protection from the elements, especially for those persons who may be particularly susceptible, for physical or psychological reasons, to these potentially adverse conditions, provides a hygro-thermal indoor environment which is both healthful and comfortable, is free from excessive noise from both interior and exterior sources of the structure, has natural and artificial means of illumination that are safe and adequate for the fulfilment of all normal household activities and functions, is free from toxic and/or noxious odours, chemicals and other air contaminants or pollutants, has adequate but not excessive microbial and thermal characteristics, provides adequate protection from insects and rodents which may be reservoirs and/or vectors of disease agents, and is served by the necessary or desirable

health, welfare, social, educational, cultural and protective community services and facilities".

It is important to note that many features of a healthy home are open to a great deal of personal interpretation and will mean different things to different people and vary accordingly among and within countries. However, what is important is the awareness of how these features can affect health.

The impacts of inadequate housing on health are difficult to measure and some people may even consider diseases transmitted through poor housing as normal or minor ailments. However, the health effects of poor housing can be fatal as unsatisfactory housing reduces the quality of life for many people. For instance, inadequate housing coupled with poor nutrition, have the ability to cut the average life expectancy at birth by 10 to 20 years (UNCHS, 1996).

The relationship between housing and health is discussed in detail in the next section.

2.3 The Relationship between Housing and Health

The historical connection between housing and health is well documented in the literature and several studies have clearly articulated the relationship (Dunn, 2003; Ranson, 1991; Krieger and Higgins, 2002; Dunn, 2000; Pevalin *et al,* 2008; Acevedo-Garcia et al, 2004). However, while the association between housing and health and wellbeing has been widely recognized, the relationships are complex and the causal links between the different dimensions of housing and health can operate at a number of interrelated levels.

Dunn et al (2003) have developed a framework of housing as a socio-economic determinant of health when they identified gaps prevalent in understanding of the housing and health relationship. Since studies have demonstrated a positive association between social status and health status, Dunn et al outlined three aspects of housing that are especially relevant to health.

1. **Material dimensions of housing** are concerned with the physical integrity of the home such as state of house repair; physical, biological, and chemical exposure; and housing costs. Dunn notes that housing costs are critical because they are one of the largest monthly expenditures most people face. When housing costs eat up the majority of a person's income, it affects other aspects of their lives. The

availability and affordability of housing plays an important role in relationship to other social determinants of health. People can go without many things, but going without basic housing is potentially catastrophic. For instance, if people are required to spend increasing proportions of available resources on basic shelter, the resources available to support social determinants of health such as food and educational resources are reduced.

2. **Meaningful dimensions of housing** refer to one's sense of belonging and control in one's own home. Home is also an expression of social status - prestige, status, pride and identity - all of which are enhanced by home ownership. These dimensions provide surface for the expression of self-identity, and represent permanence, stability and continuity in everyday life. Access to adequate and appropriate housing at an affordable price is one of the essential human needs for even basic survival. There is a great deal of literature on housing affordability but it does not address the health implications (Bramley, 1994; Hulchanski, 1995; Linneman & Megbolugbe, 1992; Whitehead, 1991). Low-income households pay a high percentage of their income for relatively poor quality housing compared to higher income households. What matters is how much money a household has left over for other essentials, such as nutritious food, medicine, and other essential goods and services.

3. **Spatial dimensions of housing** refer to a home and its immediate environment, for example, the proximity of a home to services, schools, public recreation, health services and employment. While these include systematic exposure to health hazards such as toxins in the environment they are also about the geographic availability of resources and services in relation to one's abode. This consideration introduces the need for understanding the policy dimensions associated with the availability of resources and services in communities.

Evidence indicates that lack of material resources contributes to illness and disease, a situation made worse by the stress and uncertainty of living in such conditions. Unaffordable housing and housing insecurity do not occur in a vacuum. As observed by Bryant (2003), policy decisions have the ability to create the conditions that influence the availability and affordability of housing and other social determinants of health. The availability and cost of housing has direct material effects on health. Policy decisions can

also reduce financial resources, with direct material effects on health. Both types of policy decisions contribute to housing insecurity, increased stress and increased incidence of social exclusion, illness and disease.

Literature demonstrates that while the mechanisms through which specific aspects of housing affect health do exist, they are complicated (Dunn, 2000). Researchers have made a great deal of progress in clarifying some of these mechanisms as outlined in the proceeding discussion. In general, efforts to define these mechanisms are more advanced in relation to physical, chemical and biological exposures and physical characteristics of housing than in relation to the social, economic, and cultural characteristics of housing.

While numerous studies research the influence of housing conditions on disease, accidents and psycho-social problems, the difficulty in controlling for confounding variables has made it extremely difficult to attribute a specific health condition to housing alone (WHO, 1961). For this reason, it can be argued that any modification of the physical environment will have the maximum effect on health only if accompanied by other socio-economic and environmental improvements (Harpham et al, 1988). For this study, the issue is not whether housing affects health but how specific aspects of housing and its environment may or may not affect specific aspects of health.

2.3.1 An Overview of Housing and Health Research

The association between housing and health and wellbeing has been widely recognized. However, the relationships and causal links between different dimensions of housing and health are complex. It has been known for a long time that the strongest social determinants of health are socio-economic factors although it is difficult to prove causally. Housing is the most critical social determinant of health (Dunn, 2000). In the late nineteenth century, Friedrich Engels (1872) observed that there is a relationship between housing, socio-economic status and health. However, he concluded that the relationship was clearly based on the sanitary housing conditions. The primary burden of illness at the time included acute and infectious diseases, which could be transmitted easily by casual contact. Under such conditions, the relationship between housing, social inequality and health were more easily apparent, and it was clear that housing and sanitary conditions were instrumental in the different distribution of health status by social status (Dunn, 2000). In 1944, the London Association for Education established that bad housing was

associated with high sickness rates, especially infectious illness (Centre for Addiction and Mental Health, 2007). The effect of substandard housing on health was later developed in Victorian England, where public health officials observed that slum housing conditions prompted disease and ill health in humans (Kearns 1995 cited by Dunn, 1999:3). Much of early public health policy in the UK was then directed at the improvement of poor housing environments. This is because infectious disease at the time was deadly and required the intervention of an effective policy, something that Marsh (1999) argues was inspired by the urge for self-preservation on the part of the middle classes as well as a concern for the welfare of the poor. At that time, improving housing was seen as central to improving public health.

The health dimensions of housing policy in Britain were prominent through to at least the slum clearance programmes of the 1960s.

Since then, the relationship between housing and health has been investigated in many studies. Wilkinson (1999) observed that several major reviews have attempted to pull the disparate evidence, fragmented between different disciplines, together, further arguing that these reviews are prefaced with a health warning on the quality of the evidence, which draws attention to confounding factors. While numerous studies research the influence of housing conditions on health, it has been difficult to attribute specific health condition to housing alone (WHO, 1961). The housing and health relationship has always been complex for various reasons including the following:

- Housing and health studies find it difficult to separate or even take into consideration other confounding factors such as poverty, poor nutrition and lack of medical care. People who already suffer from ill health may tend to live in substandard housing due to different confounding factors exacerbated by their low or lack of income (Ranson 1991).
- The direction of cause and effect pertaining to the relationship between housing and health variables is often unclear, due to the fact that people in poor housing may suffer many other deprivations that assessment of any one risk factor is almost impossible, and hence the direction of cause and effect in housing and health research has often been unclear (Wilkinson, 1999).
- Indices for measuring health and the hygienic quality of housing are often insensitive, inappropriate and lack universal acceptability, more especially indices

that are used for measuring aesthetic effects of housing on social wellbeing and those used in measuring the comfort levels or qualitative aspects such as the quality of life.

Nevertheless, Ranson (1991) has argued that the lack of scientifically determined parameters that outline the relationship between housing and health does not denote the absence of the relationship. The proceeding sections will start by looking into the various studies that have discussed the relationship between housing and health in general before moving into specific studies that discussed the relationship of housing and HIV/AIDS.

2.3.2 Recent Research in Housing and Health

There is a well-established literature on the impact of various aspects of poor housing upon health although documenting the relationship has been a challenge and a variety of conclusions on the relationship have been reached. As already mentioned, the body of literature in housing and health have proven that problems of confounding variables where housing characteristics are embedded with poverty, illness and social problems has made it difficult for the housing and health relationship to be established clearly.

Nevertheless, several studies have shown some association between some housing aspects and health outcomes, particularly linking housing quality with morbidity from various diseases including:

- Infectious respiratory diseases such as tuberculosis and asthma are common in overcrowded and damp housing spaces. These are exacerbated by internal temperature and humidity in poorly ventilated houses which lead to dampness associated with respiratory problems and allergic reactions to the growth of mould (Wilkinson, 1999; Gingles et al, 1995; and Krieger and Higgins, 2002).
- Poor ventilation has been reported to lower the standard of indoor air quality which has also been associated with respiratory problems (Gingles et al, 1995; Goromosov, 1968; Wilkinson, 1999; Martin, 1977 and Lowry, 1990).
- Overcrowding has been reported to facilitate the transmission of communicable diseases including skin infection as well as causing stress that leads to illness (Atkinson and Merkle, 1993; Birley and Lock, 1997; Wilkinson, 1999; Bishart and Teak, 1985 and Martin, 1977).

However, these studies have outlined that the relationship between housing and health is not direct and somehow a challenge to establish. For instance, Whitehead (2000) acknowledged the difficulty of the relationship by outlining that:

> 'The enormous increase in interest in understanding the relationship between housing and health that occurred in the 1990s and which looks set to continue well into the twenty-first century comes from similar concerns that housing may exacerbate or even directly be the source of poor health. However, the postulated relationships are far more complex, rarely having a clear technical basis... (p339)

Due to the evidence of housing's composite effects on health being unclear and complex; the housing-health relationship seems to be often underestimated by both housing practitioners and policy-makers when they develop the housing intervention strategies and policies. Marsh (1999) observed that housing environments frequently do not feature in longitudinal analyses of health status, and when they do, single or simple indicators are typically employed. In line with this observation, Aidala and Sumartojo (2007:1) proposed that in order to influence the development of housing policies that are in alignment with the health needs and beneficial to the people at-risk, there is a need to provide a justification that housing is related to the health outcome. Further arguing that in the absence of experimental verification healthy housing leads to reduced risk and stronger health of affected persons and communities, a compelling explanation for the association is needed. Similarly Allen (2000) and Oldman and Beresford (2000) have emphasized the importance of production of clear empirical evidence outlining that there is a strong relationship between housing and illness, justifying not only the importance but also the urgency of housing to health outcomes of people.

Dunn (2000) has since separated the housing and health research into four different categories: health selection and housing; health and homeless people; housing pathology and housing, stress and health. He argues that the relatively large body of contemporary research on housing and health has been primarily concentrated in these areas, each of which is discussed below in turn.

a. Health Selection and Housing

The hypothesis of research work in this area is that of reverse causality with the main aim of investigating whether housing provision improves health. Dunn (2000) indicated that this work has primarily been confined to the UK, where there is an institutionalised policy

designed to give priority in public housing allocation to people of medical priority and there is a great interest in evaluating the effectiveness of public housing programmes directed at people of medical priority. Blackman et al (2003:22) outline that over 90 per cent of local housing authorities in England have systems in place to give priority to re-housing applicants regarded as 'in need to move place based on medical grounds or medical care needs'. Medical priority re-housing (MPR) is used to facilitate housing moves that are intended to be therapeutic hence allocating properties on the basis of health and mobility needs. Blackman, et al (2003) assert that the system is based on the premise that 'some houses are more conducive to good health than others' and with the assumption that re-housing will lead to health improvements. Research studies have provided evidence of health improvement after medical priority re-housing, reporting a general improvement on mental health, a mixed response for improvement on the physical health and a reduction in symptoms and use of health services. However, Thomson et al (2001:187) argue that because of the methodological limitations of studies on health selection and housing, it is impossible to specify the nature and size of health gains that may result from a specific housing improvement.

b. Health, Housing and Homelessness

Studies in this research area focus on the link between health and homelessness. They have reported that the link is direct and evident: homeless people are susceptible to a vast array of illness and injury as a result of physical and psychological stress. The health status of homeless people has been found to be far worse than that of the general population (Dunn, 2000). Homelessness has been associated with a wide range of chronic health problems including substance abuse, mental illness, physical and sexual violence, and infectious diseases such as tuberculosis and HIV infection (Aidala and Sumartojo, 2007; Aidala et al, 2000;Wolitski, et al 2007; Kriger and Higgins, 2002). Homelessness and living in substandard and temporary housing has been related to behavioural problems, and the fear of being homeless is a psychosocial stressor that can lead to mental health problems (Daly, 1996; Matte and Jacobs, 2000; Dasinger and Speiglman, 2007; Aidala and Lee, 2000).

Aidala (2006) further argues that homelessness and unstable housing denies the individual's benefits that come from good housing, such as lowered stress, increased social capital, improved identity and increased meaning. While housing helps to structure the private sphere and build relationships, the stress, social isolation, and marginalization

associated with unstable housing and homelessness are in turn associated with increased risk of behaviours that may lead to HIV infection or transmission such as unprotected sex, needle sharing as well as to deteriorations in health and well-being.

Although these studies provide ample evidence of the relationship between health and homelessness, Dunn (2000) argues that they have two important research gaps:

i. They implicitly dichotomise society into those who are homeless and those who have homes and proceed to analyse health status along this societal split. Dunn further argues that while this is a valid inquiry, it is well established that there are sizeable health inequalities across the entire social spectrum and the homelessness and health literature mirrors a common tendency in health research to reduce health gradients to the effect of absolute poverty alone.
ii. Due to the extent that homelessness and health research considers the causal pathways and mechanisms linking housing and health, the analysis is often restricted to a narrowly bounded set of individual factors, thereby failing to appreciate fully the influence of socio-structural factors.

Matte and Jacobs (2000) have similarly argued that homelessness presents unique cases as it provides hardships beyond those presented by poor quality housing. For instance, illness, disease and nutritional deficiencies common among homeless people are exacerbated by their lifestyle. Homeless women lack the physical security of a home and consequently have an increased potential to experience more severe physical and sexual assault leading to sexually transmitted infections as well as being at a high risk of HIV/AIDS contraction (Daly, 1996:114).

c. Housing Pathology

This area consists of studies that investigate the pathological consequences of housing on health through linking various housing conditions to various aspects of health. Particular emphasis has been on mental health outcomes and physical health outcomes. The investigation of the links between housing and mental health are concentrated on overcrowding, high rise housing, housing type and location or a spectrum of housing conditions including dampness, cold, noise and disrepair to mention a few (Martin, et al 1987; Ranson, 1991; Hopton and Hunt, 1996). Research work on the relationship between

housing and physical health has been concentrated primarily in Great Britain rather than in other parts of the developed world where the housing stock is relatively new and therefore of generally good quality hence fewer concerns about pathological threats to health from housing (Dunn, 2000:351) and the housing and health tradition is more established (Bryant, 2003:53). Krieger and Higgins (2002), in their study, which particularly linked poor housing quality with morbidity from infectious respiratory diseases has established that there is a solid relation between housing and health. The study found that there is a strong linkage between substandard housing and an increased risk of chronic illness. For instance, damp, cold, and mouldy housing is associated with asthma and other chronic respiratory symptoms, even after potentially confounding factors such as income, social class, smoking, crowding, and unemployment were controlled for. Parkinson et al. (1999) have reported similar findings showing that housing concerns such as odour, noise, and condition of furniture are negatively correlated with satisfaction with housing, satisfaction of basic needs, and overall life satisfaction among people with serious mental illness.

Overcrowding, inadequate heating, insulation and ventilation were found to increase interior moisture and condensation, consequently encouraging mould, fungi and other micro-organisms to grow (Wilkinson, 1999). Many moulds in damp houses are allergenic and provide a food supply for roaches, respiratory viruses, moulds and house mites which are also potential allergens. At certain stages some fungi become toxic; mould allergy is a recognised cause of asthma. Cross-sectional epidemiological studies have also established associations between damp and mouldy housing and recurrent headaches, fever, nausea and vomiting, and sore throats (Gingles et at, 1995; Goromosov, 1968; Wilkinson, 1999; Martin, 1977 and Lowry, 1990). Whilst studies on pathology and housing emphasise that the housing conditions have a direct and indirect effects on health it is important to acknowledge that economic factors have a role in this equation. Page (2002) suggested:

> "People on low incomes, long term sick or the mentally ill often find themselves in the least desirable of homes with significant dampness. By their very socio-economic position they are least able to afford to heat their homes to a recognised level of comfort."

d. Housing, Stress and Health

Studies in this area have specifically examined the stress associated with unaffordable and/or inadequate housing, and its consequent impact on health status. They demonstrated

that housing stressors are significantly associated with psychological distress and that living in a substandard dwelling represents an independent and added source of stress to the lives of occupants, particularly those with lower income (Kearns and Smith, 1993). The experience of such stressors is an incomplete representation of the importance of housing to the stress and health impact that people who are marginalised in the housing market might experience. To this, Kearns and Smith (1993:277) argue that these psychological experiences cannot be described in a series of statistical tables and conceptual diagrams. As such, this research area requires the use of methods that provide accounts of the experience of the housing problems which draw attention to a possible mechanism for the relationship between housing and mental health. Studies in this area not only draw attention to a possible mechanism for the relationship between housing and mental health but also to socio-cultural mechanisms and hence incorporate the often neglected social issues (Kearns and Smith, 1993).

The implication of research into housing, stress and health is that poverty, housing and health are connected, but the pathways and mechanisms are not well developed. Aidala and Sumartojo (2007) argue that substandard housing poses direct health risks as it has psychosocial consequences and serves to limit social interaction. In their research findings, they highlighted that people in sub-standard housing, in poor neighborhoods, or in transient housing arrangements, experience a reduced sense of safety, personal efficacy, and personal value - all of which are associated with health problems. They further argue that the socio economic circumstance of individuals and families are equally important to their health status as is their medical care and personal health behaviors.

Common among the four categories of research that outlined the relationship between housing and health, in the preceding discussion, is the finding that the health risks associated with poor housing are directly caused by the housing design, construction and maintenance of houses. In fact, matters that might seem purely economic, such as the supply and affordability of housing in any given locality, are significant health issues.

However, housing also forms part of the social environment that people use in their daily lives hence a social determinant of health and has been outlined in studies that support the hypothesis that improving the material quality of people's lives through housing has the potential to bring significant improvement in their health. As apparent from the foregoing discussion, many studies on the subject are focused on genetic, biological factors and

health behaviours – all related to medical intervention. However, research has indicated that major determinants of health and well-being are not solely based on medical intervention but also in social, economic and cultural dimensions (Dunn 2000; Naidoo and Wills, 2001, Bryant, 2003). To this Dunn (2000: 343) noted,

> "one's immediate social and economic environment and the way that this environment interacts with one's psychological resources and coping skills, shapes health much more strongly than the medical model would suggest."

In developing countries, health problems related to housing are frequently environmental and are usually associated with poverty and rapid urbanisation (Cooper et al, 1991, Verhasselt, 1985, von Schirnding, 1992 and World Bank, 1993a). The literature, while admitting to the difficulty of establishing a link between a particular illness and individual causal factors, demonstrates the now well accepted complexity of the technical, political, institutional and cultural facets in the health and housing relationships. Nevertheless, there are three outstanding observations that seem missing in the housing and health literature.

Firstly, most of the literature available is primarily limited to the US and European contexts where the housing and related policies are relatively established; there is a scarcity of literature from Sub-Saharan African where unhealthy housing is widespread particularly in informal housing markets and the housing and related policies are at infancy stage of development.

Secondly, most housing and health studies distil the unique effects of housing conditions from other potential variables that may influence health. The approach they adopt searches for the association between the material aspects of housing independent of personal characteristics and other health determinants. These studies usually say little about how life situations interact with policy environments to create situations of disadvantaged housing. Furthermore, they also say little about the relationship between housing and other social determinants of health. Research that attempts to isolate the effect of poor housing is unable to measure or capture the complexity of and interaction among the determinants of health.

Thirdly, there has been limited research that explores the relationship between poor housing and the risk of HIV/AIDS or the contribution of poor housing to the behaviours that expose people to risks associated with HIV/AIDS, particularly in countries of Sub-

Saharan Africa where the epidemic is most intense. The next section will explore the relationship between housing and HIV/AIDS and review the debates apparent on the area.

2.4 Relating Housing and HIV/AIDS

Since the early 1990s models of housing for PLWHA have focused on improving health and well-being (Hendriks & Leckie, 1993; Stajduhar & Lindsay, 1999). In the early days of the AIDS epidemic, hospice and home based care were common housing models providing care and services to individuals and their families during their final days. Advances in medical treatments have allowed PLWHA to live longer and healthier lives. Housing models have also shifted; there is more independent and long-term support as found through independent settings often desired by PPLWHA (AIDS Housing of Washington, 1998). What has not changed is a continued focus on the connection between housing and positive health outcomes for PPLWHA. Over the last few years through the work of the National AIDS Housing Coalition, there has been a surge in new research exploring the previously under-discussed topic of housing and health among PPLWHA. Recent HIV/AIDS housing research has focused on the connection of housing to health related outcomes. Researchers found positive relationships between stable housing and HIV prevention (Coady et al, 2007; Des Jarlais et al. 2007; German et al. 2007; Weir et al. 2007), access to and engagement in care (Aidala et al., 2007; Bennett et al, 2007), maintenance of care (Aidala et al., 2007; Smith, 2000), and improved health outcomes (Leaver et al., 2007). Such a focus of HIV/AIDS research is not surprising considering the AIDS epidemic and its devastating effects. Furthermore, the focus on improved health outcomes resonates with the current global political and social environment encouraging continued support for research and care for PPLWHA. Although previous research is substantial in its attention to the individual characteristics that relate to housing need, little attention has been given to the community conditions that may contribute to housing instability among PPLWHA.

There has been a growing acknowledgement that preventing HIV risk requires understanding of the environment in which the HIV risk exists (Weir et al, 2007). Housing as a basic need and a primary facet of everyday life can be conceptualized as an important social determinant of health which plays a fundamental role in determining the physical and social risk environment. A number of studies have demonstrated associations between housing and HIV risk. Reports produced by the National AIDS Housing Coalition in 2005

and 2007 have provided evidence that housing is a key factor affecting how people live with HIV/AIDS as well as outlining the implications of housing for HIV/AIDS treatment and prevention. NAHC (2007) promotes adequate housing as a basic human right; a necessary component to HIV care and treatment; and a mechanism to end the AIDS epidemic. Cisneros (2007) posited that housing should be amongst the initial steps of intervention for prevention and treatment of HIV/AIDS, arguing that although housing by itself does not guarantee the end of the HIV/AIDS problem for the PLWA, it provides them with a stable place to live and ultimately contributes to their healing process. Cisneros (2007) and Aidala, et al (2005), in the same tone, argued that living in poor housing is a source of chronic stress where the stress of daily survival needs predominates and can supersede efforts to reduce HIV risk.

An interesting development in HIV/AIDS research is that much attention has since shifted from analysis of community housing conditions as a factor influencing people's health, to focus more on the special risk groups and the housing characteristics that position those people at risk of both homelessness and poor health outcomes (Aidala and Sumartojo, 2007). These studies emphasize the need for the policy makers to incorporate housing into the intervention policies and strategies aimed at the persons who are at-risk and/or HIV-infected.

In order for the studies to have a potential positive contribution in the HIV/AIDS and housing research, Aidala and Sumarjoto (2007) have suggested that these three important aspects be considered empirically by researchers of housing and HIV: firstly, the need to clarify the correlation between HIV and housing; secondly, the need to provide a justification of how and why the association between the two exists and thirdly, to identify how safe, stable and sanitary housing can improve the care and health of persons living with HIV/AIDS.

Although extensive literature outlines the relationship between housing and HIV/AIDS in developed countries, there is still limited evidence from the developing countries.

2.4.1 A General Review of Literature Linking HIV/AIDS to Housing

Leaver et al, (2007) have since detached the housing and HIV/AIDS research into different categories arguing that a large body of contemporary research in this area is primarily

concentrated on the importance of housing status and housing stability based on the following four aspects: access to and utilization of health and social services; access and adherence to HIV treatment regimens; health status of PLWHA; and HIV risk behaviour outcomes of people living with HIV, all outlined below in turn.

a. Health Care, Treatment and Social Service Utilization

Studies in this area aim to examine the relationship between housing status and access to anti-retroviral treatment. These studies have shown that unstable housing is significantly associated with health care and social service utilization. For instance, a study in Cote d'Ivoire carried out on 711 PLWHA reported that people with poor housing conditions were significantly less likely to be involved in a United Nations-sponsored HIV drug program in that country; and more likely to miss receiving anti-retroviral therapy (Msellati et al, 2003). Similarly, in Florida (USA), a study of four public health clinics highlighted that homeless clients were more likely to miss receiving HAART as compared with housed clients (Lieb et al, 2002).

b. Adherence to Anti-retroviral Treatment

Housing instability has the potential to be a predictor of lack of adherence to Anti-Retroviral Therapy for some PPLWHA who are in unstable housing. NAHC (2007) have outlined the relationship between more stable housing status and improved engagement, adherence to, and continuity of care, including Highly Active Anti-Retroviral Therapy (HAART). They further reported that PPLWHA who are homeless and unstably housed are, at all stages of the illness, almost three times more likely than those with stable housing to be outside of the HIV medical care system. In France a study sample of 445 PPLWHA from 47 specialized HIV care facilities reported that unstable housing status and poor housing conditions were the strongest predictors of non-adherence to ART (Spire et al., 2002) as compared to better adherence which was reported in people living in stable housing including those living with a partner, friend or relative in a home or apartment (Carballo et al., 2004).

c. Health Status of Persons Living with HIV/AIDS

Leaver et al (2007) have reported that there have been a small number of studies that assess housing and HIV status outcomes; outlining that this may be due to the high cost

associated with conducting utilization and adherence studies, particularly since such research include longitudinal studies and using clinical indicators (such as viral load and CD4) and measures of quality of life as health status outcomes. Nevertheless, a multilevel analysis of HIV positive persons in Alabama (USA) found that stable housing was significantly associated with better physical health functioning as measured by CD4 and T-cell counts, but was not associated with better mental health functioning (Stewart, et al, 2005).

d. HIV Risk Behaviours of Persons Living with HIV/AIDS

Research suggests that structural interventions, such as housing, are critical components of HIV/AIDS prevention strategies. Whereas most current prevention efforts aim to directly change individual behaviour (e.g., needle sharing, unprotected sex), Aidala, et al (2005) argue that improvements in housing status can also have an important effect on these risk behaviours. Various studies report that people who are stably housed are less likely to engage in these behaviours that lead to infection or transmission of HIV. For instance, a National US longitudinal study specifically designed to examine the relationship between housing and HIV risk-behaviour outcomes of drug use and sex risk-taking behaviours among people living with HIV/AIDS found that housing status was significantly associated with increased HIV risk behaviours of drug use (hard drug use, needle use and sharing) and sexual risk behaviours (unprotected sex and sex in exchange for money, drugs or housing/a place to stay) (Aidala et al, 2005). However, follow up interviews indicated that over time there was a 50% improvement on reduction in drug use, needle use, needle sharing, and unprotected sex for PLWHA in stable housing.

Overall, the majority of studies that link housing to HIV/AIDS originate in the U.S and are focused on samples of urban population especially on easily identifiable PPLWHA and they are rather more focused on access and utilization of care and HIV treatment adherence. However, they indicate that stable housing has an effect on reducing risky behaviours, improving health outcomes, and increasing access to care.

2.4.2 Studies Linking HIV/AIDS to Housing in Africa

While there is an increasing awareness of the HIV/AIDS epidemic and housing crisis in most of the African countries, there is little discussion of the interaction between the two

areas. This gap in the literature may be because from the outset policymakers and researchers, as well as the concerned public worldwide, have categorized the HIV/AIDS pandemic primarily as a medical and health problem. Therefore, most of the financial resources mobilized in combating the pandemic have been focused predominantly on biomedical issues (Collins and Rau, 2000:2). As the epidemic advanced, activists linked up with public health authorities in order to draw in more responses to the epidemic. This included carrying out research that aims to bridge the gap between public health responses and HIV/AIDS through embracing some of the social, cultural and economic realities of groups affected by the HIV/AIDS epidemic.

Nevertheless, most studies that have discussed the relationship of HIV/AIDS and housing are frequently focused on these two areas: impact of the epidemic on land related issues; and the Home Based Care intervention in caring for PPLWHA, both discussed in turn.

a. HIV/AIDS and Land

Studies conducted in Kenya and Uganda on the impact of HIV/AIDS on land found that HIV/AIDS puts PPLWHA into destitution to the extent of making them lose their most valuable assets such as land and housing (discussed in chapter 3). These studies highlighted that in order to cope with the economic impact of HIV/AIDS, there was a clear sequence of 'asset liquidation' among PPLWHA which followed a common order: exhausting of personal savings; then depleting business income (if any); and then disposing household movable assets, finally disposing of immovable assets including land and housing. However, they reported that disposing of land and housing presented profound consequences for people completely losing their economic base. Households with the fewest livelihood options were the most vulnerable in these situations (Kamusiime et al, 2004; Aliber et al, 2002)

The Southern African Regional Office of the Food and Agricultural Organization (FAO) of the United Nations similarly undertook a three-country study into the impact of HIV/AIDS on land issues in Kenya, Lesotho and South Africa. This empirical research confirmed that HIV/AIDS does seriously impact on a range of land issues and livelihood strategies. The study was mainly aimed at exploring the impact of HIV/AIDS on three pertinent issues in land including: different forms of land use; the land rights of women and orphans as well

of the poor generally; and the functioning of land administration systems all summarise below.

The impact on land use –Studies conducted on the impact of HIV/AIDS in Africa have focused more on the farm-household level where agricultural production at the subsistence or small-scale level is often embedded within multiple livelihood strategies and systems (Drimie 2002:5). This study found that HIV/AIDS-affected households generally have less access to labour and capital to invest in usage of their land, and are less productive due to limited financial and human resources. Ill-health, and time spent in caring for the sick reduces time spent in land utilisation, leading to under-utilisation of resources and reduced productivity.

The impact on land rights - In the context of HIV/AIDS, PLWHA need assurance that they will not lose their land rights without compensation; and that their children will be able to inherit the property; and that they are able to borrow money using the land as collateral. This is particularly vital for families and can put increased emotional and psychological pressure on members who are sick or at a later stage of HIV/AIDS. According to Drimmie (2002), the focus on land rights in the FAO study considered the extent of the impact of HIV/AIDS on the terms and conditions in which households and individuals hold, use and transact land. Apart from its other impoverishing effects, HIV/AIDS compels households to strip themselves of their land rights (primarily through land sales) which diminish the resources the household has available to meet their basic needs including food and housing.

The impact on land administration- In the study that explored the impact of HIV/AIDS on land administration in Kenya, Lesotho and South Africa, Drimmie (2002) indicated that traditional land management institutions play a central role in the mediation between overlapping claims to land rights. However, the study reported that there were variations in these diverse cases. For example, in Lesotho, traditional authorities were seen to protect vulnerable households from losing land left lying fallow. However, members of the community raised the issue of alleged land grabbing done by unscrupulous family members particularly from widows and orphans.

In South Africa, traditional authorities ensured that land rights protected vulnerable households such as widows and orphans; which are necessitated by increased reports of

land grabbing. What came clear in the countries' case studies was that women and orphans are particularly vulnerable to losing their land rights as households are impacted by the epidemic, and often they are dependent on the compassion of the traditional authorities for protection despite the fact that land rights are a particularly sensitive issue in the context of HIV/AIDS. The study recommended that protection of these vulnerable groups must be an issue that is acknowledged in policy processes.

b. Housing and home based care for AIDS patients

Another housing related area that has gained the interest of researchers in the light of HIV/AIDS is home based care of AIDS patients, a practice which plays an important role in the care of PLWHA in sub- Saharan Africa. Home based care is defined by the World Health Organisation as:

> "The provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health including care towards a dignified death." (Campbell et al, 2004:1)

PPLWHA often constitute a large proportion, if not a majority, of people seeking medical treatment at hospitals. Many hospitals do not have adequate resources to care for HIV patients. In response, hospitals and Departments of Health have implemented policies to promote home-based care of AIDS patients. Home-based care has the potential to benefit the person living with HIV/AIDS and their family members as it allows the sick person to be cared for in a familiar environment and affords them opportunity to prepare for their death and die with dignity at home (Ndaba-Mbata and Seloilwe, 2000; Campbell et al, 2004; Akintola, 2006). Several studies[2] have been done in different countries to consider the challenges facing home based carers and indicating the types of support they need. While home based care is a good initiative which entails the care of AIDS patients within their family homes by family members, with regular visits by health personnel, the

[2] For detailed discussions on Home based care in various African countries see the following studies:
Lindsey, E., Hirschfeld, M and Tlou, S (2003) Home based care in Botswana: Experience of older women and young girls: Health Care Women International 24 (6) 486-501;
Robson, E (2000): Invisible carers: young people in Zimbabwe's home based health care. Area 32 (1): 59-69;
Uys, L (2002) The practice of community caregivers in home based HIV/AIDS project in South Africa. Journal of Clinical Nursing 11 (1): 99-108;
Zimba, E and Mcinerney, P (2001): The knowledge and practices of primary caregivers regarding home-based care of children in Blantyre, Malawi. Curationis 24 (3) 83-91

programme is more health focused. There is very little attention given to the physical environment, which is the housing environment that the actual care of the patient is taking place and the social and economic conditions faced by the patient. Hence Ogutu, (2002) argues, 'in conditions of poverty in which households lack access to basic needs such as housing and food, the PPLWHA will die of poverty-related causes irrespective of the availability of the medical support.'

The ongoing discussion has indicated that housing is one of the key socio-economic factors that influence health and that sanitary and stable housing has a direct positive effect on HIV/AIDS prevention, treatment and health outcome. However, in spite of this evidence, housing has been inadequately addressed in HIV/AIDS policy discussions. To date there is lack of empirical research that explores the relationship between HIV/AIDS and housing or the impact of HIV/AIDS on housing in Botswana, (this will be outlined on the proceeding chapter). However, the country is ranked amongst the worst HIV/AIDS prevalence rates in the world and continues to confront high levels of poverty and a significant housing problem (Kerr and Kwele, 2000:3). This study is an attempt to fill the gap in literature of housing in Botswana.

2.5 CONCLUSION

Much of the research investigating the links between housing and health has shown strong independent associations between housing conditions and health. Poor housing has been as a target for interventions to improve health and reduce inequalities in health. Although housing still has a prime place on the health inequalities agenda, it also has wider importance because small health effects can have a large impact at the population level. The health risks associated with poor housing go beyond those directly caused by the design, construction and maintenance of houses. In fact, matters that might seem purely economic, such as the supply and affordability of housing in any given locality, are also in significant part health issues: Inability to afford adequate housing drives many families into overcrowded housing, frequent evictions and episodes of homelessness, all of which have consequences for the families' health, both mental and physical. Stress stemming from living in dilapidated housing, from fear of eviction or homelessness and from a generally unhealthy environment has been strongly linked to physical illness, depression and other long-term emotional distress. The importance of focusing beyond the physical environment is also recognised in literature. The long-range consequences of unhealthy

housing aren't limited just to the well-being of residents and their increased need for health care. The costs of unhealthy housing are also borne by the surrounding neighbourhood and the wider public.

The quality of housing has been outlined to have a direct effect on health even though it is difficult to prove empirically. However, good quality housing is in short supply in many developing countries although it is needed to prevent illness and maintain good health. Inadequate housing has been recognized as a risky context that leads to behaviors that have increased potential for exposure to and transmission of the HIV virus. Literature indicates that people who are in stable housing are less likely to engage in behaviors that are likely to lead to infection or transmission of HIV thus making housing a key part of a comprehensive prevention strategy. Studies elsewhere have outlined that in order to address health disparities, it is important to address key social determinants of health such as housing. If housing is a critical social determinant of health and is associated with both exposure to HIV infection and poorer health outcomes, then it is important to consider provision of good quality stable housing to the public. The next chapter provides a synoptic background to HIV/AIDS in Botswana. It proceeds to giving a summary of housing provision in Botswana, discussing the contribution and role played by both the formal and informal housing market in provision of housing for the poor in general and PPLWHA especially.

CHAPTER 3: HEALTH, HIV/AIDS AND HOUSING IN BOTSWANA

3.1 INTRODUCTION

This chapter presents various discussions that provide background and introductory information that is crucial to understand HIV/AIDS in a Botswana context. This will be achieved through developing an understanding of the scope and impact of HIV/AIDS from the broader perspective in sub-Saharan Africa before discussing HIV/AIDS from the Botswana context especially. The discussion will take into consideration the culture, economic and social problems that are apparent in the region. The chapter will then proceed to giving a summary of housing provision in Botswana, discussing the contribution and role played by both the formal and informal housing market in provision of housing for the poor in general and PPLWHA especially.

The chapter will be divided into six broad sections for setting the study's context and focus. Each section will describe the problem, and draw from available literature from other researchers within the related areas. Where important gaps in knowledge exist, these will be highlighted.

Section 3.1 provides the introduction and outline of the different sections of this chapter.

Section 3.2 will give an insight into the reality of HIV/AIDS by giving a general background to the epidemic in sub-Saharan Africa, highlighting the social and economic devastation of the epidemic for individuals, households and communities.

Section 3.3 will draw the links between HIV/AIDS and poverty, then continue to add the gender dimension onto the link: arguably the central structures that put people into vulnerable situations and promote behaviours that expose them to the risk of HIV contraction. Further discussion will focus on how the trio should be considered together in the development of intervention programmes and policies, with particular emphasis on housing development programmes and policies.

Section 3.4 will discuss specifically the HIV/AIDS epidemic in Botswana giving a statistical elaboration of the extent of the epidemic and the national response to it. The section will further give an analysis of the intervention strategies in place to help the PLWHA in Botswana.

Section 3.5 provides a synoptic background to housing delivery in Botswana discussing the development of the country's national housing policy as well as outlining the housing markets that are in operation in Botswana.

Finally, section 3.6 will offer a summary of what has been presented in the chapter.

3.2 BACKGROUND

HIV/AIDS is a relatively new and fatal disease which is as yet incurable. As May (2003:3) suggests, HIV/AIDS might be considered as '...the first great pandemic of the twenty-first century'. In 2007 a total of 2.1 million people died of AIDS, and the death toll will remain high in the future because 33.2 million individuals are currently infected and there are about 2.5 million new infections each year (UNAIDS, 2007).

This section is intended to give an insight into the reality of HIV/AIDS by giving a general background to the epidemic with emphasis to sub-Saharan Africa. A connection between poverty and HIV/AIDS will be highlighted to show the contribution of under-development to the social and economic devastation of the epidemic for individuals, households and communities.

3.2.1 Defining HIV/AIDS

Human Immuno-Deficiency Virus, commonly known as HIV is a virus that affects certain white blood cells, CD4 - T helper cells[3], that manage human immune system responses. HIV is detected directly in the blood of the infected person. At the point of very advanced HIV infection a person develops a disease known as AIDS (Acquired Immune Deficiency Syndrome). The duration before HIV has damaged the immune system enough for AIDS to

[3] HIV is parasitic on CD4 – T helper cells which are central to the body's immune system. The virus uses the human cell to reproduce themselves through damaging the host cells, consequently weakening the body's immune system. When the blood cells are damaged, it becomes difficult for people to fight off infections or diseases (for more details see Hart and Rhodes 1996, Barnett and Whiteside, 2006)

develop can be up to ten years on average, varying between populations and between individuals within populations. On average, an AIDS patient can live for up to two years without treatment or for a reasonably longer period if they are on the newly developed anti-retroviral therapies.

HIV/ AIDS constitute one of the most serious crises currently facing human development. The HIV/AIDS epidemic appears to have come into existence in the mid to late 1970s, possibly in the United States, but because of the long latency period, was not detected until 1981. The first cases of AIDS were recognized in the United States in 1981 amongst homosexual men. The illness was soon seen in a number of other countries. In Africa, Barnett and Whiteside (2006: 31) reported that the first cases were documented in Uganda in 1982 and from then the epidemic spread rapidly across the globe.

3.2.2 The Scope of HIV/AIDS in Southern Africa

One aspect of the HIV/AIDS epidemiology that is common worldwide is the epidemic's tendency to place socially disadvantaged[4] groups at greater risk of HIV infection, which, in the countries in the West in the 1980s, were homosexual men, minorities, and injection drug users. In Africa, however, the situation was different; AIDS is manifested primarily as a heterosexual disease and the earliest groups infected were long-distance truck drivers and commercial sex workers (Williams et al. 2002:29; Burayo 1991; Marcus 2001:110; May, 2003: 3; Webb 1997:5).

Although HIV/AIDS is found in all parts of the world, some areas are more afflicted than others. What has become clear is that statistics on HIV/AIDS varies widely among populations. Table 2.1 provides an insight of the distribution of the number of people living with HIV/AIDS and the prevalence rate across the world region.

4 The label "socially disadvantaged" in the African setting may mean a host of aspects including endemic poverty and lack of empowerment, conditions that describe a majority of the population due to the extraordinary burdens the effects of the disease have placed upon them.

Table 2.1: Regional Statistics for HIV/AIDS by end of 2007		
Region	**Adults & children living with HIV/AIDS**	**Adult HIV prevalence**
Sub-Saharan Africa	22.0 million	5.0%
Asia	5 million	0.3%
North America, Western & Central Europe	2.0 million	0.4%
Latin America	1.7 million	0.5%
Eastern Europe & Central Asia	1.5 million	0.8%
North Africa & Middle East	380,000	0.3%
Caribbean	230,000	1.1%
Oceania	74,000	0.4%
Global Total	**33.0 million**	**0.8%**

Source: Adapted by author from UNAIDS (2008a) and Avert (2009)

The distribution of HIV/AIDS shown on Table 2.1 indicates that the majority of the infections occur in low income developing countries. The African continent has been hardest hit by the epidemic. Particularly HIV/AIDS is widespread in sub-Saharan Africa, which recorded the highest number of PLWHA relative to other continents. Asia also has a growing number of people living with HIV/AIDS followed by North America, Western & Central Europe.

Statistical evidence on the scope of HIV/AIDS is available through various sources. However, firm reliable statistics about the epidemic are difficult to obtain as different sources report varying statistics on the epidemic. May (2003) warns that HIV/AIDS statistics should be treated with 'extreme caution,' primarily because of either over-reporting or under-reporting. Similar concerns were echoed by Kalipeni *et al* (2004:59), who noted that most data on country-wide rates of HIV/AIDS are extrapolated from small

study samples and hence their representation of the entire population becomes questionable. Although the data may not be accurate, they nevertheless offer useful insights into the general trends.

Taking note of the caution from commentators on the statistics on HIV/AIDS, it is nevertheless clear that various sources confirm that sub-Saharan Africa region is undoubtedly the focus of the HIV/AIDS epidemic in the world as it is heavily affected by HIV/AIDS infection than any other region of the world. Since HIV/AIDS was first clinically identified in 1981, UNAIDS Report on the Global HIV/AIDS Epidemic (2008a) reported 19 countries worldwide with the highest prevalence of reported infections to be all in sub-Saharan African. An estimated total of 22.5 million people in sub-Saharan Africa are infected with HIV, which translates to 68% of the worlds HIV-infected population (UNAIDS, 2008a).

Within the sub- Saharan Africa region, Southern Africa is its worst-affected sub-region with eight of its countries not only recording a national adult HIV prevalence exceeding 10% but also being the top eight countries worldwide with the highest prevalence. Table 2.2 presents a statistical overview of the AIDS epidemic in Southern Africa.

Table 2.2: Country - specific HIV and AIDS Estimates, Southern Africa (2007)

Country	HIV adult prevalence rate World rankings	Total population	People living with HIV/AIDS	Adult (15-49) prevalence rate %	Women with HIV/AIDS	Orphans due to AIDS
Swaziland	1	1,133,066	190,000	26.1	100,000	56,000
Botswana	2	1,815,508	300,000	23.9	170,000	95,000
Lesotho	3	2,125,262	270,000	23.2	150,000	110,000
South Africa	4	43,997,828	5,700,000	18.1	3,200,000	1,400,000
Zimbabwe	5	12,311,143	1,300,000	15.3	680,000	600,000
Namibia	5	2,055,080	200,000	15.3	110,000	66,000
Zambia	6	11,477,447	1,100,000	15.2	560,000	600,000
Mozambique	7	20,905,585	1,500,000	12.5	810,000	400,000
Malawi	8	13,603,181	930,000	11.9	490,000	560,000
Angola	26	16,941,000	190,000	2.1	110,000	50,000
Mauritius	30	1,250,882	13,000	1.7	3,800	<500
Madagascar	48	19,448,815	14,000	0.1	3,400	3,400

Source: Adapted by author from UNAIDS (2008a) and Avert (2009)

Table 2.2 highlights several important factors:

Firstly, those countries worst affected by the HIV/AIDS in the global context are predominantly countries in Southern Africa where countries can least afford the direct and indirect costs associated with the epidemic due to other social ills such as, poverty, poor health care and malnutrition.

Secondly, the estimated HIV/AIDS prevalence rate of adults (15-49 years of age) in countries in Southern Africa is overwhelming in some countries. For example, Swaziland,

Botswana and Lesotho have prevalence rates of over 20% and that could be argued to represent a very large proportion of all deaths in those countries.

Of importance to note is that gender differences in the event of the epidemic remain evident. Table 2.2 highlighted that the number of women infected by HIV/AIDS is high in most countries. Collins and Rau (2000) noted that in Sub Saharan Africa alone, an estimated 55 % of the infections were reported in women and this was the only region in the world where infection rates on women are higher than that of their male counterparts. More about gender and HIV/AIDS will be discussed in later sections of this chapter.

Dealing with HIV/AIDS has been one of the major public policy issues in most of the heavily affected countries in sub-Saharan Africa (UNDP, 2002:1). However, emphasis has been primarily on the health and biomedical perspective and therefore efforts to counteract the epidemic have been more focused on health issues, risk groups and behavioural change models. It is apparent that although people are informed about the epidemic and its consequences, cultural, social and economic realities constrain their individual actions and behaviours in response to containing the spread of HIV/AIDS as the epidemic is still spreading unabated in most countries. However, an important issue that literature tends to miss when discussing the causes of HIV/AIDS in African countries is that Africa is a diverse continent; made from many different countries that have diverse cultural, political, social and economic backgrounds. Oppong and Kalipeni (2004:48) criticised researchers who usually over-generalise the African continent portraying it as homogeneous despite its rich cultural mosaic and differences in geographical, economic and historical experiences. Different countries have been attempting to tackle AIDS in different ways, some with positive effects, while others seemingly making little progress.

As yet, there is no cure for AIDS. However, it is important to acknowledge that treatment and prevention of opportunistic infections can help to improve the quality of health for those diagnosed with HIV/AIDS. To date, there have been major advances in clinical treatment. There is a modern medical therapy that can delay the life threatening symptoms of AIDS which is known as anti retroviral drug treatment (ART)[5]. This has therefore

[5] HIV antiretroviral drug treatment (commonly known as either ART's or ARV's) is currently the main type of treatment for HIV/AIDS. The treatment consists of drugs that have to be taken on a daily basis for the rest of a person's life. The anti-retroviral treatment does not cure AIDS but their main aim is to keep the amount of HIV

transformed HIV/AIDS into a partially manageable chronic condition. However good the benefits of ARTs, there are some weaknesses in terms of HIV transmission: on the positive, they directly prolong the life of the PLWHA and reduce the pain of suffering from related opportunistic diseases. On the negative side, and important to note, ART increases the pool of people infected with HIV/AIDS within countries, which can be argued to have a potential to heighten the risk of transmission (Barnett and Whiteside, 2006).

The magnitude of the epidemic in Africa has attracted comments and debates around the world, including debates on the progression of HIV/AIDS in Africa particularly questioning as to why the HIV epidemic does not diminish. For example, Barnett and Whiteside (2006:168) argue that sub-Saharan Africa possesses a risk environment where susceptibility to disease is high due to poverty; however, they have not ignored the role played by behaviour and attitude in HIV transmission. Caldwell (2000) argues that behavioural change has limited the AIDS epidemic elsewhere but the approaches employed have not been tried in African countries on a national scale. For instance, members of the gay communities and commercial sex workers are recognised as groups with specific sex risks in Australia and Thailand respectively and hence governments have responded through making publicity campaigns in collaboration with these groups, consequently recording a fall in HIV prevalence for them. However, in Africa gay members, commercial sex workers and prostitutes are still stigmatised and not given the support they need to prevent and manage HIV/AIDS (Caldwell, 2000:119). The South African government have been criticised in that respect. The Lancet (2005) said:

> "Social stigma associated with HIV/AIDS, tacitly perpetuated by the Government's reluctance to bring the crisis into the open and face it head on, prevents many from speaking out about the causes of illness and deaths of loved ones and leads doctors to record uncontroversial diagnoses on death certificates.... The South African Government needs to stop being defensive and show backbone and courage to acknowledge and seriously tackle the HIV/AIDS crisis of its people." (p546)

In addition to the foregoing discussion, there are several other underlying factors that could explain the high prevalence rate in sub Saharan Africa. For most of the heavily affected

---

in the body at a low level. This stops any weakening of the immune system and allows it to recover from any damage that HIV might have caused already (Avert, 2009; United Nations, 2004).

African countries these include poverty at both household and national levels as well as the gender inequalities that are widespread among the African communities. The next section discusses the relationship of poverty and HIV/AIDS.

3.3 HIV/AIDS AND POVERTY

Barnett and Whiteside (2006) observed that the conditions that facilitate the rapid spread of an infectious disease are by and large those that make it hard for societies to respond, and which make the impact severe, including socioeconomic inequality and poverty. HIV/AIDS, like all communicable diseases, is directly linked to poverty. AIDS has always been a disease that has financially devastated the affected people and has the ability to cause poverty to some non-poor families and households and deepen the poverty for those already living in poverty. The deepening poverty across the African continent in particular has created fertile ground for the spread of infectious diseases including HIV/AIDS. Poverty restricts people's choices and leaves few options but to undertake "high risk behaviours[6]."

Collins and Rau (2000) have observed that poverty is most often cited by those who comment on the socio-economic context of the spread of HIV. They posit that poverty and HIV/AIDS are interrelated. However, it is important to acknowledge that the relationships between HIV and poverty are not simple and direct. The relationship is inclusive of other more complex structures and conditions some of which are exclusive to certain countries and communities as observed by Drimie (2002:7) and Collins and Rau (2000) and include: inequalities and imbalances in income and asset distribution such as lack of access to resources and services to some people including women and the poor; unregulated socio-economic and demographic changes such as rapid population growth and rural-urban migration.

Before proceeding to outline the role of poverty in HIV infection, it is important to define the term 'poverty' as used in the study.

[6] For example, Collins and Rau (2000) identify poverty-driven labour migration and commercial sex work as activities likely to increase HIV infection.

3.3.1 Defining Poverty

Poverty is a fluid, multi-faceted term which cannot be associated with any one measurable indicator and is often difficult to either define or measure[7]. Studies on poverty have attempted to define the term 'poverty' but as Gordon *et al* (2000) observed, the task of defining poverty is difficult for two reasons: the definition has to be inclusive of the various political ideologies, broad concerns of the physical and nutritional needs of human beings and their complex social needs; there are different conditions particularly between the rich and poor, developed, developing and under developed countries.

In realisation of this challenge of defining poverty, an international agreement at the Copenhagen World Summit on Social Development in 1995 recommended a two-tier measure of 'absolute' and 'overall' poverty to be applied to every country, a means of bringing all governments together in common purpose (Gordon *et al* ,2000).

In a nutshell, 'absolute' poverty is defined in terms of severe deprivation of basic human needs' while 'overall' poverty is a wider measure, including not just lack of access to basics but also lack of participation in decision-making and in civil, social and cultural life.

Absolute poverty:

> "A condition characterised by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to services." (UN, 1995:57)

Overall poverty can take various forms including:

> "Lack of income and productive resources to ensure sustainable livelihoods, hunger and malnutrition, ill health, limited or lack of access to education and other basic services, increased morbidity and mortality from illness, homelessness and inadequate housing, unsafe environments and social discrimination and exclusion. It is also characterised by lack of participation in decision making and in civil, social and cultural life. It occurs in all countries: as mass poverty in many developing countries, pockets of poverty amid wealth in developed countries, loss of livelihoods as a result of economic recession, sudden poverty as a result of disaster or conflict, the poverty of low wage workers, and the utter destitution of

[7] The World Bank's measure of poverty is the percentage of people living below an income of one dollar per day (Parker et al, 2000).

people who fall outside family support systems, social institutions and safety nets." (ibid)

According to an internationally adjusted standard of absolute poverty, Sub-Saharan Africa has been estimated to have four times as many poor people as non-poor (World Bank, 1997:208). While the international definition of poverty is inclusive and relatively relevant to most countries of the world, there is a need to note that the extent of poverty varies from country to country as well as within individual countries in terms of people likely to be experiencing it and the degree to which it is experienced. In the African context, this disparity is evident between the rural and urban areas and between men and women.

3.3.2 The general impact of HIV/AIDS on poor households

Cohen (2002) noted that HIV/AIDS and poverty are inter-related and inter-linked. He commented that poverty and deprivation cause ill health and ill health causes poverty. Studies remind us that while HIV/AIDS is concentrated in poor populations and the people most hard-hit by HIV/AIDS are the poor, HIV infection is not confined to the poorest (Masanjala, 2007; Colin and Rau, 2000; Barnett and Whiteside, 2006, World Bank, 1997:28). Many of the non-poor are also infected and affected; however those with higher incomes, it is thought, have significantly fewer constraints to ceasing to engage in behaviours that expose them to the risk of contracting HIV/AIDS. Drimie (2002:7) noted that many factors which predispose people to HIV infection and transmission are aggravated by poverty which creates an 'environment of risk' for HIV transmission. These include primarily the affordability problems of the affected people or their countries. Decosas (2002) observed that HIV/AIDS strikes hardest where poverty is extensive, and public services are weak. Allen and Thomas (2000) observed that poverty contributes immensely to the infection and transmission of HIV/AIDS especially where countries, communities and households can least afford the direct and indirect costs associated with the epidemic. While poverty aggravates the transmission, spread and the impact of HIV/AIDS, on reverse, the effect of HIV/AIDS is believed to intensify and prolong poverty in every context and at both micro (individual and household) and macro (national and global) level. UNDP (2000:2) observed that the HIV/AIDS epidemic is 'the antithesis of human development' due to the nature of its impact. It strikes at the very core of human development: shortens human life, erodes people's sense of dignity and self-esteem, causes social exclusion and traumatises and impoverishes individuals, families and whole

communities. At a family level, HIV/AIDS have impacted on the economy of poor households who commonly lack savings and other assets which can mitigate the impact of illness and death; they are already on the margins of survival and thus are unable to deal with the consequent health and other costs.

On the other hand, the social impact of HIV/AIDS is evident in the continent's orphan crisis. According to Drimie (2002), the epidemic has increased significantly the number of orphans in sub Saharan Africa due to the fact that the HIV/AIDS illness and mortality often affects people in the age range of 15 to 49 years of age. Avert (2009) and UNAIDS (2008b) reported that in 2007 there was an estimated total of 11 600 000 AIDS orphans in Sub Saharan Africa. The impact of AIDS has challenged the family social support system and has broken down the traditional extended family support network system. As a primary unit for coping with disease and its consequences, families and households bear most of the social impact of the HIV/AIDS epidemic. Traditionally orphaned children were cared for and supported within the extended family[8] safety net, which remains the predominant caring unit for orphans in communities with severe HIV/AIDS epidemics. However, the traditional African family support systems and structures have been significantly overwhelmed and stretched very thin by the rapid rise of AIDS orphans. Unfortunately, most families that are faced with the care of orphans are also faced with poverty: therefore taking in orphans is a significant burden on their already limited resources. Meeting the welfare needs of the affected families such as food, clothing and psycho-social support have been outstanding in national debates on caring for AIDS orphans and vulnerable children. Many studies and reports have articulated the problem of an overwhelming increase of orphan children and pointed out the extended family as a safety net for care of the orphans (see Avert, 2009; Foster and Williamson, 2000; Physicians for Human Rights,2007; UNAIDS,2008b). Condemned to a life of poverty the orphans require a decent standard of living. There has been a limited exploration of how the extended families caring for orphans cope with their housing needs although the problem is already a challenge to many poor households in Africa. The housing problem transcends the scope of

[8] Extended families involve a large network of connections among people extending through varying degrees of relationship including multiple generations, over a wide geographic area and involving reciprocal obligations (Foster and Williamson, 2000). In this context, family and sometimes friends are expected to provide guardianship and foster support to orphaned children.

need for shelter reported in many studies because caring for orphans increases not only the socio-economic needs of the foster family but also increases their need for additional sanitary living space to accommodate the orphan(s).

At a national level, much of the developing world has affordability problems that limit most the country's ability to purchase and administer medical drugs, even for treatment of simple sexually transmitted infections, which has already been reported to heighten the risk of HIV transmission. Anti-retroviral treatments are not widely available and even unaffordable to some governments to purchase for their population in need. In such instances, some of the PLWHA (especially the poor people with affordability problems), whose lives could have been prolonged by the use of ARV deteriorate in high numbers to become AIDS patients, eventually die a relatively premature death (Masanjala, 2007:1036).

Nevertheless, although some developing countries that are relatively rich have the capacity to provide free or subsidized life-prolonging ART to those who are infected with HIV and in need of the therapy, two important questions comes to mind and still remain to be answered. Firstly, how long will the subsidised and/or free ART will be available to the PLWHA considering their cost implication on the country's economy in the long-term? Secondly, what will happen to the pool of PLWHA who depend on ART at the time when the country falls short of being able to purchase and therefore reduces the supply of the treatment, considering that the therapy requires a lifetime adherence?

While poverty has been widely debated to be an undeniable background to exacerbate the impact of HIV/AIDS, it is important to point out that the association of poverty to an increased HIV prevalence does not necessarily indicate a causal relation but increases susceptibility to infection. Explanations have been offered at several levels as to how poverty may increase susceptibility to HIV/AIDS elsewhere: see Loewenson & Whiteside 2001; Cohen 2000; Whiteside, 2002; Mbaya, 2002, Kalipeni et al, 2004.

Significant to note is that literature provides a clear and direct relationship between poverty and the epidemic at household level. However, there has been a contradiction that has attracted some powerful critiques at a national level particularly because HIV prevalence

has been noted to be highest in some of the most economically advanced countries in Africa.

> "Indeed, Southern Africa, which contains several of the countries with the highest HIV prevalence, is the most economically advanced region within sub-Saharan Africa. Currently, this group of hardest-hit countries has, on average, higher levels of education, higher levels of access to improved sanitation and water sources, higher levels of public expenditure on education and health, and lower levels of child and adult undernourishment.." (United Nation, 2005:8).

For example, South Africa[9] and Botswana[10] which have a relatively high per capita income in the sub Saharan Africa region also have the highest levels of HIV prevalence rate in Africa. On observing this variance, Barnet and Whiteside (2006) noted that national wealth alone is not a defence against the HIV/AIDS epidemic; other factors contribute to the problem. Part of the answer to the variance may lie in the rapid economic growth both countries have experienced since their independence. Szreter (1999) argues that rapid economic growth has always entailed disruptions which threaten to spill over into deprivation, disease and death. Socio-economic growth necessarily involves the formation of new values and norms as well as disruption of existing structures. For example, Barnett and Whiteside (2002) noted that economic growth and change may have an influence on the social values within societies. Livelihoods strategies that come with economic growth may facilitate faster change of sexual partners between and within diverse groups in the community (which may have been conservative and traditional) as social changes such as migration of people in search for economic opportunities creates a network of a variety of people through moving within and between communities. However, should be noted that the concept of economic growth alone is not sufficient to explain the spread of the HIV/AIDS epidemic in these countries; there are other structures that play an important role. These include economic distribution such as poverty, cultural dimensions such as gender inequality, cultural practices and patriarchy, all which need to be considered among the underlying factors that contribute to the spread of HIV/AIDS (Whiteside, 2000).

---

[9] Ranked 4th in Africa and 62nd in the world (CIA, 2006)

[10] Ranked 6th in Africa and 64th in the world (CIA, 2006)

In many developing countries, poverty and inequality between women and men are both strongly linked to the spread of HIV/AIDS. The relationship of the three structures; HIV/AIDS, poverty and gender need a closer elaboration as they form a focus in the debates on vulnerability to HIV/AIDS and hence it is discussed in the next section

3.3.3 Relationship between Poverty, Gender Inequality and HIV Vulnerability

Poverty and gender inequality are inextricably intertwined and common in Africa as they are in other developing countries. The relationship between poverty and gender is clearly outlined in the literature. A disproportionate share of the world's poor includes women and girls. UNAIDS (2008a) global estimates indicate that women constitute roughly fifty per cent (50%) of all people living with HIV/AIDS worldwide and an estimated sixty per cent (60%) of them live in sub-Saharan Africa.

In linking poverty, gender inequality and HIV/AIDS, Drimie (2002:19) observed that inequalities in gender are parallel to inequalities in income and assets and hence women are vulnerable not only to the infection of HIV but also to the economic impact of HIV/AIDS. Schoepf (1993:57), as quoted by Collins and Rau (2000), also noted that conditions operating in a context of pervasive gender inequality have different effects on the lives of women in different regional, class and family circumstances and backgrounds.

Several factors may be attributed to contribute to the interplay between poverty, gender and HIV/AIDS, particularly factors which heighten vulnerability of poor women's risk to HIV infection and its impacts. These include biological, socio-economic and cultural factors, all considered below.

a. Biological Factors Contributing to Women's HIV/AIDS Vulnerability

Biologically, women are more susceptible to HIV infection than men because of the hormonal changes, vaginal microbial ecology and the female physiology. Physicians for Human Rights (2007) reported that;

> "The vaginal mucosal barrier is particularly vulnerable to viral invasion and the resultant systemic infection. Furthermore, the vaginal vault provides a large surface area for HIV transmission into the body during intercourse through semen, which

contains a high concentration of the HIV virus. For these similar reasons, women are at higher risk than men for other sexually transmitted infections (STIs) such as herpes simplex infection. STIs decrease mucosal integrity, increasing susceptibility to infection with HIV (pg.8)."

Forced sex, which has been reported to be a serious concern in the Sub Saharan region, has been reported to increase the likelihood of vaginal tears, facilitating the transmission of HIV in affected women (Physicians for Human Rights, 2007). The vulnerability of the affected women is further heightened by the lack of access to health facilities for treatment of STI's. As Caldwell (2000) observed, in places where health facilities are unaffordable or even unavailable to the poor, the persistence of ulcerating untreated and uncured STIs heighten the vulnerability of the affected women to HIV infection. Furthermore, the nutritional deficiency due to poverty faced by poor women depresses their immunity and slows the healing process of the STIs (Caldwell, 2000; Stillwagon, 2002).

b. Socio-Economic Factors contributing to the vulnerability of Women to HIV/AIDS

Women in most African societies do not to enjoy similar rights and a similar full legal status as their male counterparts. The social status accorded to women in many African societies, undermines their rights, contributes to their lack of access to and control over economic resources, exposes them to violence perpetrated against them, and deprives their access to information about HIV (WHO, 2009:13).

In many African societies, gender inequality is evident where women are viewed as subordinate to men (Ankrah, 1996:103). In addition WHO (2009) observed that gender inequality is the most prevalent form of social inequality that is generated by society's written and unwritten norms,[11] rules, laws and shared understandings.

---

[11] Socio-cultural norms define and set limits on issues that may be negotiated as well as behaviour that is acceptable and tolerable. Socio- cultural norms reflect the dominant perceptions on the needs and rights of women and men in a community. Furthermore, socio-cultural norms may set limits on women's employment outside the home or in certain fields, which in turn restricts women's income earning capabilities and weakens their bargaining power (Kalabamu, 2005)

Kalabamu (2005:65) noted that gender inequality is attributed to the unequal distribution of power between men and women, whereby men draw their power from culturally constructed rules on marriage, inheritance, work, social status and participation in politics and other extra-domestic activities. In this way, some women may make choices to the detriment of their health in order to conform to societal expectations rather than what would have been their independent preferences. For example, women may not have the power to negotiate safer sex, for instance through condom use, in order to please their partners consequently exposing themselves to the risk of contracting HIV.

Furthermore, most women often have little control over the sexual behaviour of their husbands, or protection from the consequences of male behaviour. This is more evident in communities where 'polygamy[12] is practiced and accepted as a social institution and hence most men and women believe that men are biologically created to need sexual relations with a variety of women (Caldwell, 2000:5). As a result of these socio-cultural norms and based on societal expectations and fear to meet those expectations, some women may allow their husbands to have several wives. Being in a polygamous marriage undoubtedly exposes women to the risks of HIV/AIDS.

Certain cultural norms and traditional practices also contribute to women's low status by subordinating women and girls to be economically dependent on males. Widow inheritance[13] practiced in some African communities is a good example of such traditional practices. In this practice, a widow is forced to marry her deceased husband's brother in order to maintain clan relations and her status in the family, and remains prevalent in some areas. In countries such as Uganda, (Human Rights Watch 2003a), Kenya (Human Rights Watch, 2003b) and Zambia (Human Rights, Watch 2002), the traditional practices of

---

[12] Polygamy refers to marriage to more than one spouse at a time. Although the term may also refer to polyandry (marriage to more than one man), it is often used as a synonym for polygyny (marriage to more than one woman), which appears to have once been common in most of the world and is still found widely in some cultures. Polygyny seems to offer the husband increased prestige, economic stability, and sexual companionship in some cultures. Lesthaeghe (1989) quoted by Caldwell, (2000) reported that in West and Middle Africa over 40 percent of married women are still in such marriages)

[13] For the purpose of this research, widow inheritance refers to a traditional practice that is intended for the brother or male relative of the deceased to provide support to the widow and their children through gaining possession of the late brother or relative's assets and family (Physicians for Human Rights, 2007, Human Rights Watch, 2002).

widow inheritance is still common. Human Rights Watch indicated that the findings in Kenya and Zambia outlined that widow inheritance afforded protection to women who would otherwise be without economic support for themselves or their children. The original traditional practice of widow inheritance was a way of providing widows with economic and social protection. Since widows were not supposed to inherit property in their own right, being inherited provided them with secure access to their matrimonial home. However, in the light of HIV/AIDS this cultural practice of widow inheritance has become undesirable, as it means the wife inherited and the inheritor puts themselves into a high risk of contracting the disease as well. For example, in a case whereby the late husband died of AIDS, the likelihood of the widow being HIV positive is high and so is the risk of its transmission to the man who will inherit her. Similarly, if the person to inherit the widow is HIV positive and the widow is HIV negative, there is a high risk of transmission from the man to the widow. As families become aware of the dangers of HIV/AIDS, the wife inheritance practice has greatly decreased (Human Rights Watch, 2003a).

On the other hand, traditional divisions of labour disproportionately burden African women rather than men with caring for family members with HIV/AIDS. Gender roles in most African communities are aligned to traditional norms and practices whereby women are responsible for domestic running of the household. Women bear the burden of the impact of HIV/AIDS: as caretakers, breadwinners and those who are most vulnerable to HIV infection. They struggle to support families, earn income, produce food and care for the sick, while others are suffering from HIV-related illness themselves (UNDP, 2002).

The next sections of this chapter will focus specifically on HIV/AIDS and housing in Botswana, elaborating on the extent of the problem and highlighting on the national response to it.

3.4 A HISTORICAL OVERVIEW OF HIV/AIDS IN BOTSWANA

The first case of HIV- related illness in Botswana was discovered in a town named Selibe-Phikwe in 1985. Since then the virus has rapidly spread from urban areas, peri-urban areas and rural areas. To date HIV/AIDS continues to be a serious problem in Botswana, with a widespread social, humanitarian and economic impact (NACA, 2006). Botswana with a

population of less than two million people and a HIV prevalence rate[14] of 23.9% among adults aged between 15 and 49 years in 2007 is amongst the countries with the highest HIV prevalence rate in the world and is second after Swaziland with a prevalence rate of 26.1% in Sub Saharan Africa (See Table 2.2). HIV/AIDS have since reduced the life expectancy in Botswana from 65 years in 1990-1995 to less than 40 years in 2000-2005; a figure about 28 years lower than it would have been without AIDS (Avert, 2009). The unfolding pandemic has now overshadowed Botswana's economic development, especially in terms of prudent resource management and well directed economic development. It has put pressure on the health and social welfare systems.

Table 2.3: Botswana HIV Prevalence rate estimates by end of 2007 (%)

Indicator	Year	Botswana	Sub-Saharan Africa
Adults (15-49)	2007	23.9	5
Young women (15-24)	2007	15.3	3.2
Young men (15-24)	2007	5.1	1.1

Source: BONEPWA, 2009

HIV/AIDS has affected mostly the age group of economically active people within the society. Following the trend in other sub-Saharan African countries, women and girls continue to be disproportionately affected by HIV. Prevalence rate is particularly high among the young women relative to men as shown in Table 2.3. Studies elsewhere have attributed this variation to the fact that young women start their sexual life earlier than their male counterparts (Physicians for Human Rights, 2007). In observing the high HIV prevalence rate in Botswana, it is important to consider the factors that have a significant contribution to the HIV transmission in Botswana, which include:

- The practice of having multiple and concurrent partners, which has been identified as being common and therefore recognised as a key driver of HIV transmission among PLWHA in Botswana (Kalichman et al, 2007). Concurrent partnerships are

[14] HIV/AIDS prevalence rate is the percentage of the total number of HIV positive people in a given population in a particular time. For the purpose of producing a national or international HIV prevalence figure, researchers include all people with HIV infection who are alive at a given point in time, whether or not they have progressed to AIDS (Barnett and Whiteside, 2006; Avert, 2009)

relationships whereby an individual has overlapping sexual relationships with more than one person (Setswe 2008 quoted in UNAIDS and NACA, 2010).

- Male circumcision, that has been shown to reduce the risk of contracting the HIV through sexual intercourse by 70% (Bongaarts, 2008), is not widely practiced in Botswana; fewer than 20% of males are circumcised in Botswana (BONEPWA, 2009).
- Gender inequality is reported to be a problem in Botswana, due to a largely patriarchal system that makes women economically dependent on their spouses, thus increasing their vulnerability to HIV (UNAIDS and NACA, 2010).
- The practice of intergenerational sex encompassing the development of sexual relations among individuals of different generations. This increases the risk and spreads the virus across generational groups, mostly due to socioeconomic pressures (Nkosana, 2006).
- Stigma and discrimination shown to those living with HIV and AIDS. This leads people to evade and disassociate from initiatives aimed at preventing, caring and treating those infected and affected by the pandemic.
- The high population mobility of Botswana society has been reported to make the country to be one of the most mobile populations in the world (GoB, 1997). Traditionally Batswana have three abodes: the principal home in the village, the cattle post for pastoral farming, and the lands for arable farming. With increasing urbanisation some people have a fourth home in an urban area. People in Botswana usually move between these places in a complex pattern varying across seasons and the stages of an individual's life cycle. Consequently, married couples live separately for long periods of time, and young people live without their parental guidance which increases the likelihood of engaging in high-risk sexual behaviours such as multiple and concurrent partnerships and intergenerational sex (UNAIDS and NACA, 2010).

The effects of the pandemic have put pressure on the people of Botswana both at household and national level. This challenge is increasingly evident in the day-to-day lives of individuals living with HIV/AIDS in Botswana. As BONEPWA (2009) noted,

> 'People living with HIV/AIDS, those affected and their families continuously experience challenges associated with the pandemic including social stigma and discrimination, inadequate treatment, uncertainty due to global economic conditions, and vulnerability to poverty and its adverse effects.'(p.5)

Although PLWHA are faced with problems noted above, the country has however responded well to the epidemic. The collaboration of the government, civil society and international partnerships has invested significant resources in response to the epidemic. A number of intervention programmes have been put in place to focus on the prevention, treatment, care and support for people affected and infected with HIV/AIDS. These are summarised in the next section.

3.4.1 A Brief Overview of Health care in Botswana

Botswana's steady socio-economic and infrastructural development, and its political stability have made it possible for the country's to commit to providing comprehensive public primary health care services to the majority of its population (Boonstra, 2005). During the 1990s the government focused on improving the quality of services, including promoting rational drug prescription. Most of the curative and preventive health care services in Botswana are organized and provided by trained health workers in institutional primary health care services including clinics and hospitals, which provide more comprehensive health services. Primary public health care services, including medicines, are free to the general populace.

3.4.2 Background to the responses to the HIV/AIDS Epidemic in Botswana

According to Letamo (2003), the response to the AIDS crisis in Botswana started in 1987 and progressed as follows:

The response started with the development of a one-year Short Term Plan in 1987 and a broad-based five-year (1987-1993) known as First Medium Term Plan (MTP I). The latter aimed at expanding the response to the emerging epidemic into the domains of public health through information and education campaigns, and the expansion of testing and laboratory services. it focused on blood screening with the aim to reduce and eliminate the risk of HIV transmission through blood transfusion.

As the epidemic intensified, reaching an HIV prevalence of 13 percent in 1995, it became clear to the Government that HIV and AIDS were not only health problems, but that they were also development issues that cut across all sectors. Therefore the Second Medium Term Plan (MTP II), which covered the 1997-2003 periods, was designed to provide a platform for a multi-sectoral national response that exists today. The Government adopted the Botswana National Policy on AIDS, which provided for a collective multi-sectoral (individual agencies, private and public) response to fight against HIV/AIDS. In 1996, a national home-based care system for AIDS patients was announced by the government resulting in the revision of the National Aids Policy in 1998 to incorporate home-based care project[15] as a major component in the management of the HIV/AIDS epidemic. The primary objective was to reduce the pressure on the hospital system to care for AIDS patients.

From 1997 a much broader, inclusive and robust focus has been on education, prevention, and comprehensive care including the provision of anti retroviral drug treatment (ARTs). The response aimed to include the largely-neglected stakeholders, such as NGOs and the private sector, and addressed the shortcomings of the earlier response phases. The goal at this point was not only reducing HIV infection and transmission rates, but also reducing the impact of HIV/AIDS at all levels of society. The MTPII recognized that HIV/AIDS is not just a medical and health problem, but also has social, economic and cultural dimensions. The review of the Plan therefore led to the formulation of the National Strategic Framework (NSF I) for 2003-2009.

There has been a significant progress in developing and implementing programmes aimed at HIV/AIDS prevention, treatment, care and support. These include:

The Prevention-of-Mother-to-Child Transmission of HIV (PMTCT) was introduced in 1999; The National ART programme was implemented and rolled-out in 2002; Routine HIV Testing was introduced in 2004; HIV testing was further enhanced through an increase in voluntary counselling and testing centres throughout the country; National

[15] The World Health Organisation defines Home-based care as "the provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximum level of comfort function and health including care towards a dignified death" (Campbell and Foulis, 2004).

Orphan Care and Home-Based Care programmes provide important care and support for those infected and affected by the epidemic. These are each summarised below:

1. The Prevention-of-Mother-to-Child Transmission of HIV (PMTCT)

The government of Botswana established the first nation-wide PMTCT programme in 1999. PMTCT is a programme which reduces the risk of mother-to-child transmission of HIV, through the provision of short courses of antiretroviral treatment to the mother and infant before and after birth, and through counselling on infant feeding options. In Botswana, pregnant women who visit antenatal clinics (ANC) are offered HIV testing and those found HIV positive are advised to enrol in the programme. The PMTCT was reported to have achieved significant uptake in 2002 following the start of the ARV programme.

> "The uptake of PMTCT interventions among those testing positive has increased from 27 percent in 2002 to 94 percent in 2009." (UNAIDS and NACA, 2010)

The nation-wide PMTC programme has been recognised as a successful programme due to the fact that in 2007 less than 4% of babies born to HIV positive mothers were infected - a rate comparable with the USA and Western Europe (Avert, 2009; Boston Globe, 2007);

2. Anti Retroviral Therapy (ART) Programme

Botswana has been recognised by UNAIDS (2007) to be the first African country to embark on a programme of rolling out free antiretroviral therapy to most of its citizens living with HIV in need of treatment. The treatment programme began at a single site in January 2002 and after a slow start it expanded quite rapidly and successfully relative to other countries in Africa. The total of 145,190 persons on treatment as at end of 2009 was estimated to account for 89.8% of those with advanced HIV infection in need of ART. BONEPWA (2009) commented;

> "There is no doubt that the promotion and increased availability and uptake of antiretroviral (ARV) drugs has prolonged the lives of the majority of PLWHA and improved their quality of life. The benefits accrued from ARV treatment have injected hope to the majority of PLWHA and their families most of whom would have been destined to die

soon had the national free ARV treatment programme not been introduced."

ARV treatment has yielded positive outcomes at both the household and national level. Poor households who would normally find it impossible to afford the cost of such treatment are now able to access and benefit from the treatment consequently reducing the HIV related mortality rate at national level. Highly active antiretroviral therapy (HAART[16]) continues to have a favourable impact on disease progression and mortality in settings where it is available to people living with HIV. As Greener et al (2000) rightly observed, ART has a positive effect from a social and humanitarian perspective; their ability to pro-long life and reduce the pain of human suffering on the PLWHA due to opportunistic infections. Nevertheless, as already stated elsewhere in this study, ART have negative implications as they increase the number of PLWHA which can be argued increase the risk of HIV transmission due to the high proportion of HIV positive people within the population (high prevalence rate). Rising prevalence rates increase the risk of new infections among those who are currently HIV free but do not practice safe sex (Moore and Oppong, 2007). Furthermore, the administration of ARTs raises significant fiscal concerns on the government's resources.

Other national interventions on HIV/AIDS on Botswana are defined briefly in turn below, although the list is not exhaustive. It is beyond the scope of this study to discuss the programmes in-depth but nevertheless it is important to outline them in-order to provide an insight of country's efforts towards the welfare of its large population of people infected and affected by HIV/AIDS.

3. Routine HIV Testing

Voluntary counselling and testing (VCT)[17] was introduced in 2000 and since the beginning of 2004 HIV tests have been offered as a routine part of checkups in public and private

[16] Taking a combination of three or more HIV anti-retroviral drugs is also referred to as Highly Active Antiretroviral Therapy (HAART). If only one drug was taken, HIV would quickly become resistant to it and the drug would stop working. Taking two or more antiretroviral drugs at the same time vastly reduces the rate at which resistance would develop, making treatment more effective in the long term (Avert, 2009).

[17] VCT programme in Botswana provides HIV counselling and rapid testing with immediate results for the general public (See Cockcroft et al, 2007).

clinics in Botswana. However, Cockcroft et al (2007) noted that although there is interest in the Botswana VCT programme as a possible model for others to follow, there are concerns that have been raised about the implementation of routine testing, particularly about the adequacy of counselling and informed consent given to the recipients. VCT has the potential to cause problems with consent and it needs to be given consideration. Nevertheless, VCT has since increased the number of people who get tested for HIV in Botswana, consequently contributing to the high demand for HIV testing and increased acceptance of voluntary HIV testing. The availability of HIV care and treatment services is transforming the knowledge of one's HIV status (UNAIDS and NACA, 2010).

4. National Orphan Care and Home-Based Care programmes

Orphans and vulnerable children programme (OVC) is a governmental programme focused on addressing the immediate and long term needs of orphans in Botswana. Orphan care benefit in Botswana is part of the national policy on orphans and vulnerable children. According to GoB (2002c) the benefits include a monthly food basket, a school uniform, transportation fees, clothing, rental fees where applicable, and other payments as required. These benefits are received by the orphan's caregiver (guardian) or by an orphan acting as the head of the family (guardian) for younger siblings. This policy is designed to help the affected children and caregivers to cope with the impact of HIV/AIDS on family income. Although the programme is helpful and necessary for the basic needs of the AIDS patients and the orphans, it has fiscal implications as the number of orphan children who need the service is high (see Table 2.2). UNDP (2000) has already reported that the orphan care programme is generally working with limited resources to provide care for the recipients consistently and efficiently.

5. Community Home-Based Care

Community Home-Based Care in Botswana was introduced in 1992 when it became clear that public hospitals were not coping with the increasing number of AIDS patients. In this project, care is provided to individuals in their homes by their families, with support and assistance from social welfare, health workers and the wider community. Letamo (2003); Lindsey et al (2003), and Ndaba-Mbata and Seloilwe (2000) noted that community home-based care is designed to take advantage of the traditional set-up of care whereby the sick

have been and continue to be taken care of by the relatives. The study by Letamo (2003) revealed that community home-based care systems increased the willingness of relatives to care for their patients at home rather than in hospitals, something that could be attributed to the nature of care needed by AIDS patient as well as long and extended periods of illness which necessitate a home setup for care. Letamo's study also noted an increase in the participation from the non-governmental organisations that, in addition, provided psycho-social support to the patients. On considering that the initial focus of provision of good housing for people with HIV/AIDS was to assist patients in the process of dying by creating a supportive and nurturing environment with an emphasis on compassion and care as observed by Lindsey et al (2003), a community home-based care system was a step in the right direction and a good attempt to care for the infected and affected households. However, poverty poses serious problems for the home-based care programme as some households live in overcrowded and sub-standard housing that poses a health problem to both the patient (whose immune system is already compromised) and the caregiver (who could be at a risk of attracting infectious diseases from the patient) (UNDP, 2000:44).

3.4.3 Importance of good quality housing for PPLWHA

There has been growing acknowledgement that preventing and managing HIV among individuals and populations require understanding the environments in which HIV risk is produced. As a primary facet of everyday life, housing plays a fundamental role in determining the physical and social risk environment. Housing occupies a strategic position as an intermediate structural factor, linking broader societal processes to the more immediate physical and social environments within which people carry out day-to-day life. Housing can be seen as an intermediary by which the pathogenic inequality that inheres in broader economic and political structures is carried to those who have insufficient resources to carry them through prolonged or repeated periods of crisis, including PPLWHA.

People in poor housing conditions as well as those in desperate housing need such as some PPLWHA, have lifestyles that place them in situations that make it difficult for them to manage their HIV status. Good quality housing as well as housing related interventions that alleviate housing need can have a positive effect on health outcomes of PPLWHA. For instance; a clean, dry, secure housing structure is fundamental to personal hygiene,

medication storage and protection from elements. Furthermore, as a central component of social life, housing has a large impact on the size and composition of social networks. It facilitates effective interaction with other people and also increase adherence to HIV treatment plans. Furthermore, private housing space allows for establishment of stable personal relationships as housing has been shown to reduce risky sexual relationships (Lozier, 2006). Availability of affordable good quality housing has the potential to reduce anxiety and stress related-illnesses and in this way housing consequently promote improved health on PPLWHA.

Housing may also affect access to resources such as employment, education, health, and social services, not only through neighbourhood-level factors, but also through formal and informal connections to community services such as clinics and social support services essential for PPLWHA.

Figure 3.1 provides an explanation of the various aspects that good quality, affordable housing essential for improving the health and quality of life of PPLWHA.

Figure 3.1: Housing aspects important to the health of PPLWHA

3.5 A BRIEF OVERVIEW OF HOUSING IN BOTSWANA

Increasing urban growth in Botswana means that providing housing and related services for the residents is a major issue for the government, particularly those that may find it difficult to provide for themselves such as the poor and the low income becomes essential. In Botswana housing delivery in urban areas is practised in both formal and informal sectors. This section provides background and gives a brief overview of the land and housing provision in urban areas in Botswana. The provision of housing needs requires the availability and accessibility of resources including land and housing finance, which are discussed below in turn prior to focusing on the housing provision in Botswana.

3.5.1 Residential Land Tenure in Botswana: A Brief Overview

Land forms the integral components of housing provision because all forms of housing consume land. Based on that contention, the discussion of the housing market cannot be considered in the abstraction of land. The availability of serviced land that is accessible to all people in any country is a major element for successful housing programmes. The ever rising demand for land that accompanies population growth, particularly in urban places, often makes the provision of land difficult (Grimes, 1976:94). It is important to recognise that in Botswana there is a distinct difference between rural and urban land ownership systems as outlined in the next section.

Botswana has a total land area of 582 000km^2, divided into three main categories of land: Customary land, State land and Freehold land. These three categories were inherited from the British rule after Botswana gained independence when they were named Native land, Crown land and Freehold land respectively (Mathuba 2003). It is important to mention here that the state owns all land in the country besides freehold land and leases it to the public members under the various tenures outlined.

Customary land covers land in rural areas, which accounts for 70% of the total land area in Botswana. Customary land is administered through the Tribal Land Act of 1968, which is the first piece of legislation to propose substantial changes to the Tswana tribal system of land tenure (Tembo and Simela 2004). Before the introduction of this Act, chiefs used to oversee the administration of customary land but the Tribal Land Act of 1968 has transferred the administration power to allocate the land rights from chiefs and headmen to

Land Boards[18] established through the same Act. Furthermore, the Tribal Land Act modernized rural land administration and management by providing a written law for easy reference (Kalabamu, 2000). Customary land is allocated to citizens without monetary cost. However, the state retains ownership of the land and the plot holder has the land rights that are usufruct[19] for the sole purpose of erecting an owner occupied residential house. The land rights in customary land grant are perpetual, transferable and inheritable. However, customary land rights may be terminated by the state for the following reasons:

a. Failure to observe development/use restrictions attached to the lease;

b. Change of use or user of land without due authority;

c. Failure to use the land for a considerable period;

d. The land is required for public interest including land redistribution.

State land covers all urban land in Botswana as well as some pockets of land in some rural areas. State land constitutes 25% of all total land area. According to Kalabamu (2006), prior to independence, the colonial administration considered the Kalahari Desert unutilized and declared it crown land before placing it into the authority of the British monarchy. The British High Commissioner was given the power to lease or grant crown land on terms and conditions he deemed fit. The State Land Act of 1966 changed the status quo and transferred the powers from the High Commissioner to the State President or his nominee. This empowers the president to make and execute grants of any state land or of any interest therein. However, the president has since delegated these powers to the Minister responsible for land matters (Mathuba, 2003). Currently state land is leased to individuals or companies under two tenure types: Fixed Period State Grant and Certificate of Rights, each discussed below:

Fixed Period State Grant (FPSG) was introduced in 1972 and gives the lease holder a capitalized lease of 50 years for commercial and industrial plots and 99 years for

[18] The Land Boards are decentralized body corporate composed of elected members of the community. The functions of the land boards with respect to land administration have been identified as granting of rights to use land, land registration, land use planning, land use monitoring, land acquisition and land adjudication (Tembo and Simela. 2004).

[19] Usufruct is a legal term defined as the right to use and enjoy the profits and advantages of something belonging to another as long as the property is not damaged or altered in any way (www.thefreedictionary.com).

residential plots. All rents for FPSG are paid at the commencement of the lease rather than periodically over the entire lease life and at the end of the lease the land reverts back to the state with the development therein without any compensation to the leaseholder. FPSG gives the lease holder the right to sell or otherwise transfer what remains of their lease period.

Certificate of Rights (COR) is a lease system that was introduced in the early 1970s' with the main aim of providing an inexpensive secure land tenure for the urban poor in Self Help Housing Agency (SHHA) schemes and squatter upgrading schemes. The land rights in COR are perpetual, transferable and inheritable. However, the state retains land ownership whilst the plot holder has the land rights that are usufruct for the sole purpose of erecting an owner occupied residential house. COR title holders are allowed to convert to FPSG provided the plot is title surveyed and a diagram thereof approved and registered by the Director of Surveys and Mapping.

Freehold land is found in both urban and rural areas and covers 5% of the total land area in the country. According to Mathuba (2003), the size of the freehold land has been reduced over time as it is bought to augment urban state land. Freehold land near urban areas has lately been converted into urban land use for residential, industrial and commercial usage. These conversions have been made possible through the use of the Town and Country Planning Act which was enacted in 1977. Land Boards have also purchased some of the freehold land and incorporated it into tribal land for communal use (Adams, 2001). Since 1978 there has been no freehold land created, this was done to avoid concentration of land into a few hands in the country. Under the freehold tenure, land ownership is exclusive and perpetual (Kalabamu, 2000).

Land supply in Gaborone is clearly dominated by formal state structures and institutions; government owns and controls almost 95% of the land within Gaborone (Kalabamu. 2006:217). However, as Datta and Jones (2001) argue, when the government is more focused on formal land delivery, there is the potential of losing sight of what is happening to the informal supply of land as well as how households who cannot participate on the formal land structures maintain levels of affordability. Consequently, the informal housing market may be neglected.

3.5.2 The Housing Policy Context

Provision of housing was not a top priority of the government that assumed power from the British Protectorate in 1966 as it was not until 1982 that the first formal housing policy was produced. This was the first comprehensive housing policy in Botswana and was derived from the Commission Report of 1981 and the subsequent Government White Paper No. 2 of 1982 (Government of Botswana, 2003). It covered a variety of issues on both the supply and demand sides of the housing process. These included: institutional capacities, the roles of the public and private sectors subsidies, rental policy, housing standards and rural housing. The main long term goal of the 1982 national housing policy was to ensure that everyone in the country has safe and sanitary housing. Generally, it was in many ways a far-sighted document and many of its proposals endured and served the nation well over eighteen years before its review in 1999.

The policy measures that were put in place in 1982 proved to be inadequate due to among other reasons the rapid population growth and high rate of rural to urban migration in the early 1990's, consequently there was a need of the policy review. Inadequacies of the 1982 policy were evidenced by the following short-comings apparent at the time:

The acute shortage of housing which was indicated by the ever-growing housing lists of both the public and private housing providers; Overcrowding was very high in urban areas and this was linked to high rural to urban migration experienced at that time; The lands and housing cost were generally high relative to the income of the people in the country resulting in housing affordability problems.

With consideration of the recommendations raised by the Review's committee, the government Paper No 2 of 2000 on National Policy on Housing in Botswana was approved by the National Assembly in 1999 and implemented in year 2000. The main goal of this revised policy on housing was shifted from ensuring provision of safe and sanitary housing to facilitation of the provision of decent and affordable housing for all within a safe and sanitary environment. This revised policy is targeted at achieving these four main objectives:

To change the emphasis of Government from home provision to facilitation in partnership with other stakeholders,

To channel more government resources and emphasis to low and middle lower income housing in both urban and rural areas,

To promote housing as an instrument for economic empowerment and poverty alleviation and,

To foster a partnership with the private sector and all major employers in home development and facilitating home ownership.

The thrust of the revised national housing policy emphasizes what Yeboah (2005:148) terms 'plurality in housing provision'; the policy is inclusive of a wide range of housing providers including formal, the private sector as well as the Non Governmental Organizations (NGOs) housing providers. Furthermore, the aim of the housing policy to recognize the implications housing has on health by aiming to provide safe and sanitary housing, and giving the poor people a priority in the policy document; are two important aspects that are directly relevant to this study and they are a step in the right direction.

Also, the policy aim is in accord with the international housing agenda. For instance, the Habitat Agenda (UNCHS, 1996: 15) asserts that if governments make the market accessible for those excluded from participation by providing subsidies and promoting credit and other institutions, the poor may invest in housing. However, this outcome is most unlikely in Botswana, where there is increasing unemployment, a high HIV prevalence rate and a marked decline in household incomes. Nevertheless it is the aim of the national housing policy to achieve the set objectives.

Despite being revised in the wake of HIV/AIDS epidemic, there are three pertinent issues related to this study that the Botswana national housing policy has overlooked:

Firstly, while the general policy aims seem to recognize the relationship of sanitary housing and improved health, it has overlooked the integration of HIV/AIDS into the housing policy document. As Botswana has the second highest prevalence rate of HIV/AIDS in the world, one may anticipate that the epidemic be treated as a major issue of concern and be recognized as well as be integrated into all policies especially those dealing with social issues such as housing. The housing needs of PLWHA and the affected households has been a key issue of discussion in public debates. For instance, the 2008 International Declaration on Poverty, Homelessness, and HIV/AIDS recommended that

policy makers address the lack of adequate housing as a barrier to effective HIV prevention, treatment and care and that the governments fund and develop housing as a response to the HIV/AIDS pandemic. Some countries have recognized and embraced HIV/AIDS in their housing policies even before this recommendation. For example: in the USA, the Housing Opportunities for Persons with AIDS (HOPWA) program, managed by the Department of Housing and Urban Development's Office of HIV/AIDS Housing was established in 1992 to provide housing assistance and related supportive services for low-income persons living with HIV/AIDS and their families (Nussbaum, 2010:44).

South Africa has responded by conducting research into the economic impacts of HIV/AIDS on the construction sector and implications for the housing policy with the aim to identify the different impacts which the pandemic will have on the housing industry (Development Works, 2002). However, Botswana has not responded to the HIV/AIDS epidemic either through researching into the issue or adopting it into the housing policy.

Secondly, Botswana's national housing policy has elevated home ownership above other forms of tenure. As much as home ownership is a desired tenure for some of the people, it is not the only form of tenure. This policy can be criticized for hardly mentioning other forms of tenure such as renting or even recognizing their value in housing provision. Some people at various stages of life prefer to rent rather than to own a home. For instance, migrants prefer to rent or share their housing as they are in transit and often prefer to invest their money in things other than housing (Gilbert, 1983) and female headed households prefer to rent in places which offer them greater physical security and support networks and services rather than own their own homes (Datta and Jones, 2001). However, this oversight has been criticized for marginalizing the rental housing sector and ignoring the needs of the poor who may find it difficult to penetrate the home ownership market as well as those people who are not interested in home ownership (Nkwae and Dumba, 2010; Datta and Jones, 2001; Kerr and Kwele, 2000) . Nevertheless, the importance of exploring other options of housing tenure that can be used to improve accessibility and affordability of housing to the urban poor (e.g. rental tenure) in future policy decisions have been recommended by Nkwae and Dumba (2010:9). Furthermore, Datta and Jones (2001:340) have suggested that the appeal of ownership is to some extent constructed by government support through subsidies on housing related services and building materials, right to buy

policies, and pronouncements that ownership is a sound investment. However these issues don't emerge clearly in the Botswana national housing policy.

Thirdly, although the Botswana national housing policy mentions the poor and low income as target groups for home ownership, very little attention is paid to the provision of housing-related services required that will make up the plurality of providers envisioned in the policy document. Neglecting the important role of the rental market is arguably equivalent to ignoring the housing needs of the poor who according to Gilbert (1993) compose a high percentage of the population in the rental housing market in most developing countries. The focus of the housing policy is primarily on the formal housing strategies which are dominantly spearheaded by the government. Furthermore, involvement of the informal sector in providing housing is hardly addressed in the policy document although various studies have demonstrated that the informal rented housing market is dominant among the poor people in Botswana. It has been reported that a significant proportion (58%) of the inhabitants of self-help housing (which is supposedly an owner occupation housing scheme) are tenants and not owners. This confirms the importance of the informal housing market in Botswana (Datta 1996; Kerr and Kwele, 2000; Dumba and Malpass, 2000).

3.5.3 The Urban Housing Markets in Botswana

Botswana's urban housing market is highly segmented. The existing housing supply in urban areas of Botswana, including Gaborone, is delivered through the following three major housing markets outlined in figure 3.1: The public housing is delivered through the Self Help Housing Agency (SHHA), which covers 45% of the entire urban housing stock; the parastatal and private sector through the Botswana Housing Corporation (BHC) which accounts for 28% and real estate agents and private owners who account for 27% (Cavrić and Mosha 2001).

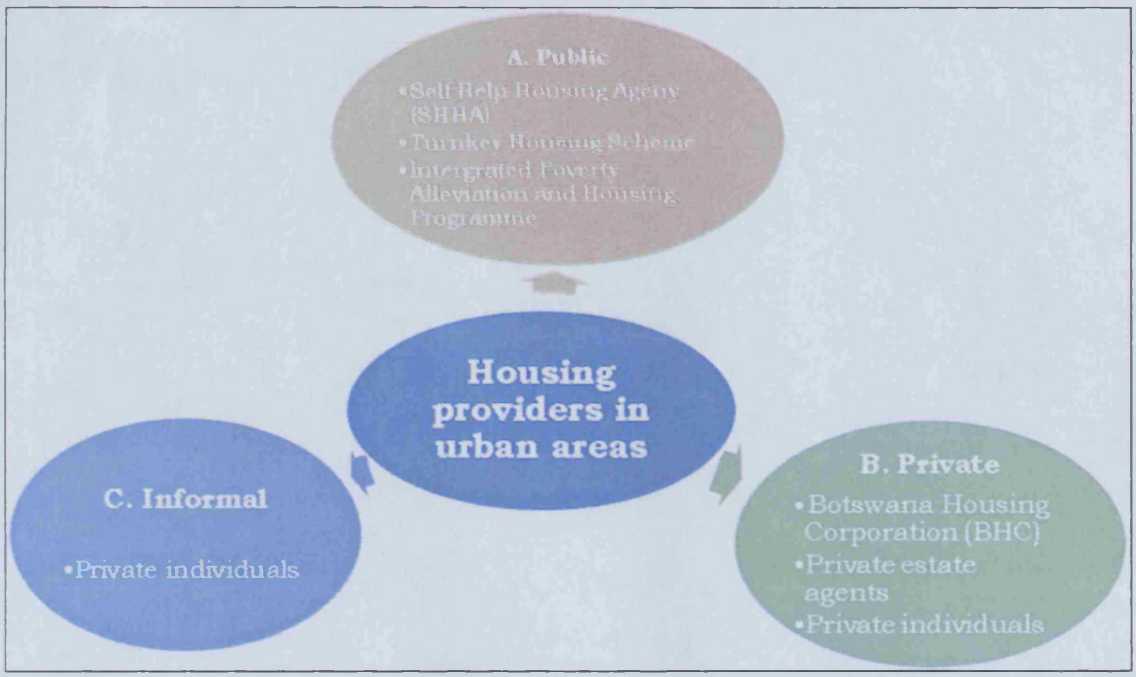

Figure 3.2: Housing Delivery in Botswana urban areas

There is a small proportion of housing which is marketed openly; either for sale or for rent through the informal housing market. However, although informal housing is practiced in Botswana, data is not systematically collected that could enable the statistics to reflect the nature and extent of informal housing provision in Botswana. This is primarily because the government doesn't recognize informal rental housing among the housing providers (this will be discussed in detail later in this section).

a. Public Housing Delivery

Botswana unlike in other countries has no social housing, which usually provides subsidized housing that meets the affordability requirements of vulnerable groups of people such as the poor and those on low incomes. However, the government of Botswana, through the Department of Housing, provides the development funding for housing schemes and programmes aimed at the poor and low income people. The government is responsible for administration, monitoring and coordination of the Self Help Housing Agency (SHHA), Turnkey Housing Scheme and the Integrated Poverty Alleviation, each discussed overleaf.

i. Self Help Housing Agency (SHHA)

From the viewpoint of self-help[20] proponents (Abrams, 1966; Mangin, 1967; Turner 1983), the government's role is to create conditions that will facilitate the poor to build their own houses. They posit that if given the support they need to construct their housing, the urban poor have the capability to build their own dwellings in accordance with their needs and priorities. In 1974, the Government of Botswana established the SHHA, which had the task of implementing site-and-service schemes with the aim to support low-income people with affordable housing. However, the programme was formally implemented in 1978 through the financial assistance of international bodies including the World Bank and United States Agency for International Development (USAID) (Ikgopoleng and Cavric, 2007).

The SHHA programme provides a plot of residential land and housing finance to low income urban dwellers. During its inception, the programme was heavily subsidised and provided the beneficiaries (low-income groups) with plots of 450m² free of charge. Plot holders were given security of land tenure through the Certificates of Right (COR). SHHA plots had flexible planning laws which were suited to meet the needs of those with low income. Due to the relaxed building standards, SHHA beneficiaries could even build the houses of very minimal quality. In 1992, the SHHA programme was reviewed; the plots that used to be allocated free started to be allocated at a charge according to the income group of the applicant. Due to the ongoing demand for new plots and lack of serviced land, the plot size was reduced to 200-300 m² for low-income people and 375-400 m² for middle income people. Houses built on SHHA plots were now required to meet the set minimum standards outlined on the Statutory Development Control Code[21].

If the applicants qualify for a SHHA plot, they automatically qualify for a SHHA building loan. However, low income rural dwellers are provided with housing finance only. They

---

[20] Self help building is distinguished from other systems of construction in that the family who live in the house participate in its construction process by making different contributions including finance, labour-power and administration (Burgess, 1985: 272). This definition suggests that self-help is not necessarily self-build.

[21] The Statutory Development Control Code is intended to regulate building construction in SHHA areas ensuring that there is a measure of safety, health, amenity access and hygiene as well as ensuring that the land will maintain its value. However, most structures in the old SHHA areas in Gaborone have not adhered to these building control and regulation measures (Gwebu, 2003)

access land from the land boards that administer land in their respective rural areas. In urban areas, SHHA applicants, who must be citizens, and be formally employed or legitimately self-employed in the town or city where the application is made, must have an annual income of between P4,400 and P24,300 (£520-£2916) for low-income plots, and between P24,301 and P36,400 (£2917-£4368) for middle lower income plots. The maximum SHHA loan has been increased from P1,200 without interest at inception to P20,000 at an interest rate of 10% in 1991 and to P45,000 in 2009 (£5400) at an interest rate of 10% repayable over 15 years (Nkwae and Dumba, 2010; Government of Botswana, 2009).

SHHA plot-holders who are unable to develop their plots are required to return their plots to the local SHHA for re-allocation to the next applicant on the waiting list. However, returned plots receive a partial refund of the total purchase price less penalty fees (Malpass and Dumba, 2000). On the other hand SHHA plot-holders who transfer developed plots within ten years of allocation are not allowed to re-register for plot allocation for a period of five years. They are also required to pay a penalty fee (lien[22]) amounting to the difference between the market price of the plot and the initial purchase price (Malpass and Dumba, 2000). Currently, SHHA areas represent the predominant land use in urban areas and accommodate the majority of the urban populace in general and in Gaborone especially. Since inception, SHHA has benefited 21 964 households in Botswana (GoB, 2008).

Nevertheless the early critics of self help housing such as Burgess (1982), Ward (1982) and Mathéy (1992) have pointed out that not every household is able to construct their own house and that the qualities of self help housing is often very poor and unsanitary. This has resulted in governments in the developing world being faced with the two-fold responsibility of improving the quality of housing in the existing self-help housing, slum and squatter settlements whilst on the other hand they have to provide housing to those without shelter (Bredenoord and van Lindert, 2010). Furthermore, research indicates that there has been a gradual paradigm shift that has seen the relevance of self-help housing

[22] A lien is defined as a legal claim against an asset which is used to secure a loan and which must be paid when the property is sold.

strategies disappearing gradually from the international and national housing policies (ibid). Botswana has also since shifted from focusing on implementation of self help as the sole strategy for provision of affordable housing for the low income people and has added other schemes such as the SHHA Turnkey scheme as discussed below.

ii. SHHA Turnkey Scheme

Low income people need decent housing and urban services; however, this has been a challenge to the policy makers in Botswana. For many years housing for low income people was provided in the site and service areas particularly through the SHHA housing programme but did not meet the minimum housing quality standard resulting in unsanitary housing conditions (Gwebu, 2003). On realisation of this problem, the government of Botswana implemented the Turnkey Housing Project in 2002 to work alongside other housing programmes designed for the low income people. The aims of the programme are two-fold: (a) to provide an alternative form of low-cost housing which will aid in assuring a decent, safe and sanitary place to live; (b) to establish the possibility of government providing completed housing structures to eligible SHHA applicants who qualify for the SHHA programme and not allocated residential plots as yet.

The programme forms part of the revised SHHA (2008) and has adopted and implemented a 'Design and Build' housing development method to provide housing for the SHHA beneficiaries (Government of Botswana, 2008b). In this scheme, the Local Authority builds a house not exceeding the value of P60, 000.00 for the beneficiaries who will then have to repay the house loan at no interest for those without arrears on their re-payments; and 10 % interest on arrears per annum within a period of 20 years.

Nevertheless, in the 1970s and 1980s the debate on housing provision for those on low income was given a high priority. Among the more influential writers on the subject were Abrams (1966), Mangin (1967) and Turner (1967, 1983) who have rejected the turnkey housing projects as an expensive standard solution for housing low income people and outlined self-help as the best option to house the poor. However, since the turn-key programme is of recent origin in Botswana and will be operated alongside the SHHA programme, its effectiveness as a programme suitable to provide housing for the low income is yet to be established.

iii. Integrated Poverty Alleviation and Housing

Research has outlined that inadequate and insecure housing are intricately linked to poverty. Consequently, most of the housing policy agendas in the developing countries are now aimed at drawing specific links between efficient housing markets and poverty reduction with the aim to use housing as a mechanism for capital accumulation for the poor (Datta and Jones, 2001:340; Omuojeni, 2006; Berner, 2000). According to Moser (1998), housing is by far the most important productive asset held by the poor and therefore can be used for economic advancement through focusing on productive activities that will eventually contribute to poverty alleviation. The idea of empowering the poor through allowing them to benefit from their factors of production, their land and labour has been adopted in housing and poverty reduction strategies. The construction of simple and functional housing through direct labour would create both jobs and income for skilled and semi-skilled people (Omuojeni, 2006).

The Botswana government initiated the integrated poverty alleviation and housing scheme in 1999 for poor people who fall below the SHHA threshold and are not qualified for the SHHA Turnkey scheme. The aim of this programme is to facilitate economic empowerment of poor households through employment creation, poverty alleviation and home ownership. To achieve its aims, the programme trains poor people in both the development of housing related micro-enterprises (such as brick moulding, brick laying) and the construction of affordable housing. The focus of the scheme is to assist the poor household to establish income generating ventures that will enable them to generate enough income and eventually construct their own houses or earn an income that qualifies them to benefit from the SHHA scheme (GoB, 2000). In 2008, The Department of Housing reported that there were 94 houses completed with 12 still under construction during the pilot programme. The programme has since been rolled out to other areas but has not yet been evaluated (GoB, 2008b).

b. Private housing market

The aims of the National Policy on Housing provide for active participation by the private sector in housing delivery initiatives. Although individuals have contributed significantly towards housing development in Botswana, the role of the private sector housing development is still low in Botswana (GoB, 2002a). Botswana Housing Corporation is the

most prominent in this sector, and there is an insignificant development by other property developers. According to the Government of Botswana (2002a) there are numerous constraints that discourage the private business interests from venturing into real estate development in Botswana. There is currently neither the legislation instrument that directs the participation of the private sector nor a framework which encourages and facilitates private sector initiatives in housing development. Furthermore, there is an over reliance of the government on BHC for housing supply in the private sector which is coupled with the slow land delivery and unaffordable housing development prices that hinder the private housing market development. Nevertheless, as Bredenoord and van Lindert (2010) argue, the private sector 'as a rule' does not offer housing products to poor people since it is profit driven. BHC is the main housing provider in the private housing market although it is partially state controlled.

i. Botswana Housing Corporation (BHC)

Botswana Housing Corporation is a parastatal corporation that is run by the laws and regulations formulated by the Botswana Parliament to govern and guide its day to day operations as well as being partially funded by the Government to discharge its duties. As a result of the large number of people who migrated from rural areas into the urban areas in the early 1970s' in search of paid employment and educational opportunities, there was a huge demand for housing. Hence, the establishment of BHC in 1971 through the Botswana Housing Corporation Act with the mandate of provision of rental housing accommodation as well as houses for lease and sale, initially for the government employees and expatriates. However, BHC could not cope with the housing demand and could only serve a proportion of the upper income groups to the total exclusion of the low income people (Keiner and Cavric, 2006). Initially BHC allocated its houses through a waiting list based on the first come first served basis, but have since 1996 shifted from maintaining a waiting list to operate in a more commercial approach; building houses on the basis of proven demand (Kalabamu, 2005). In effect, BHC has been criticized in the early 1980's for its then low rents relative to the market which attracted long waiting lists as well as for subsidizing the better off to live in high standard housing and neglecting the housing needs of those on low income (Datta, 1996; Harvey and Lewis, 1990:261). To date BHC provides accommodation in three categories to the urban population: high cost, medium cost and low cost houses. These categories are mainly distinguished by the size of

the house and supposedly correspond with the income level of the occupant. Recently BHC has been criticized for moving from its original mandate of housing urban residents to a more commercial focus which was even equated to that of a real estate agency which serves the housing needs of people with an ability to pay for housing and discriminating against those with low income (Kerr and Kwele, 2000; Mmegi Wa Dikgang, 2006). Furthermore, for some people, access to BHC houses has been through employment housing schemes. 40% of the houses built or owned by BHC are allocated, in block, to the government as per Section 4.1 of the Botswana Housing Corporation Act of 1970 (Kerr and Kwele, 2000; Kalabamu, 2005). In effect, the Government is BHC's principal client and houses reserved for the Government are allocated to civil servants and parastatal employees.

c. The Informal housing market

According to Durand-Lasserve et al (1996), a significant proportion of urban dwellers in developing countries are excluded from formal processes of access to land and housing. Faced with the lack of conventional or formal housing solutions the urban poor have virtually no other option, consequently they live in precarious conditions most of which are irregular-settlements[23] and informal housing with little or no infrastructure and services (Durand-Lasserve et al, 1996; Bredenoord et al, 2010). The informal housing market is a response to the failure of the formal and private formal sectors to supply enough housing at affordable prices to meet the needs of the low income and poor households (Payne, 1984). Informal settlements are grouped by Durand-Lasserve and Clerc (1996) into three broad categories: irregular sub-divisions, squatter settlements and occupation of dilapidated buildings.

Irregular sub-divisions, occupation of privately-owned or communal land, which has been divided into plots and subsequently sold or rented out by the land owner or their intermediary holding his brief. The informality here arises in that such developments are not sanctioned by the planning authorities' standards. This is the predominant type of

---

[23] The term "irregular settlement" includes a wide range of local situations and dynamics; it can be defined as an area or settlement where development (spatial expansion) and occupancy are not conforming to the legal, urban and environmental standards set by public authorities.

informal settlements in the peri-urban areas of most countries in Sub- Saharan Africa where cities have expanded onto land previously held under customary tenure regimes (Kironde, 2005; Midheme, 2007).

Squatter settlements include land or property occupied without the permission of the land or property owner and this could be either public or private property or land. The informality lies in the lack of consent of the legal owner of such property or land.

Dilapidated rented buildings on their part are typically rented units whose irregularity lies in the status of the tenants who usually lack formal written lease agreements; lack of compliance with the health and sanitation norms including drainage, density of occupation and safety (of the dilapidated structures) (Durand-Lasserve and Clerc, 1996).

On the other hand, UN-Habitat (2003) considers informal settlement as one lacking in any of the following conditions: access to adequate water; access to adequate sanitation facilities; sufficient living area; structural quality/durability of dwellings; and security of tenure.

The type of informality defined by UN-Habitat (2003) is the one common in Botswana where the informal housing comes in a very different type from other developing countries. In Botswana, the informal housing areas initially appeared in Gaborone and Francistown soon after independence, set up by low income workers migrating into these expanding towns. However, these informal settlements have since been upgraded through the site and service schemes and are now known as SHHA areas discussed in the preceding section. In this respect, as Malpass and Dumba (2000) observed, Botswana avoided the development of informal settlements. Although over the years in Botswana SHHA has supplied 'decent' tenant-owned accommodation for many thousands of the urban poor and low income people and benefited quite a large proportion of low income people, it did not meet the housing demand of the low income people in most urban areas (Mosha, 1995, Taylor 2003). This lack of supply of low income housing has led to the flourishing of the informal rental housing market of relatively dilapidated housing. To date in Botswana, most of the informal housing delivery is found within the SHHA areas where there is a lot of sub-letting of multiple houses within the same plot some of which are sub-standard (commonly known as rented rooms) (Datta, 1996; Gwebu, 2003; Kalabamu, 2005). It is estimated that 58% of the residents of SHHA are not owners of the plots but tenants (GoB, 1992). As

Malpass and Dumba, (2000) noted, informal housing in Botswana comes in a very different form whereby the informal housing market develops within more controlled conditions. This is different from other African cities such as Lagos, Nairobi or Johannesburg whereby informal settlements are found in the city or its outskirts. Surprisingly, up until now the Botswana government has given little recognition to the importance of this rented accommodation in the SHHA areas, yet it has provided an indispensable additional capacity for dealing with the housing shortages. This section of the housing market represents a realistic option for people who cannot afford home ownership. Informal rental accommodation in SHHA areas has nevertheless been reported to provide an important income supplement which helps to make SHHA affordable for some of the plot-owners who use their plots for income generation through room renting (GoB, 1992; Datta, 1995).

3.5.4 Housing Finance Provision in Botswana

Until recently, access to housing-related finance in developing countries has been limited (USAID, 2008). One important task to meet the housing challenges is to devise mechanisms and systems by which an adequate and steady flow of long-term financial resources from both the public and private sectors could be mobilized and channelled into housing development and particularly in low income housing development.

Literature has indicated that housing finance institutions in the formal sector have placed much emphasis on middle to high income groups (Mitlin, 1997; UNCHS, 1991; Finmark, 2007). The Habitat Agenda recognized that housing finance systems do not always respond adequately to the different needs of large segments of the population, particularly the vulnerable and disadvantaged groups living in poverty. Consequently, governments have been attracted to low-income housing finance with the aim to find programmes that reach the poor people on a sufficient scale. Pugh (1994) suggest that for governments to improve in the provision of housing finance for the low income people there is a need to attract private housing finance schemes so that together they can provide a mixture of mandated funds.

Finmark (2007) observed that the housing finance sector in Botswana continues to expand, particularly focused on home ownership and mortgage backed lending. This is usually a financially viable option for addressing the housing finance needs of people from the

middle and high income bracket. However, it is a disadvantage for the people in the low income bracket which comprises mainly of the informally self employed people. There are typically three problems of housing finance in Botswana, as in other developing countries, especially finance for poor and low income households. These include: (i) the reluctance of formal financial institutions to lend to people with low and/or irregular income; (ii) the affordability of the product; and (iii) obtaining sufficient long-term capital in markets which are typically dominated by short-term investments and personal savings. The government has responded to these issues by offering a variety of solutions from guarantees to stimulate lending and subsidies to address affordability. However, the efforts remain inadequate for the low income people as discussed below.

Generally housing finance for low income people in Botswana has been constrained despite the argument that it forms an integral part of the poverty reduction programme (Turner, 1983). Housing finance in Botswana has been largely limited to conventional housing providers: Botswana Building Society (BBS) has been the main housing finance provider for the middle and high income groups while the low income housing has been solely financed through the SHHA loan scheme.

BBS is a parastatal organization established by the government to assist in provision of housing finance with the aim of promoting affordable housing to the public. 80% of BBS mortgages are for residential properties. The interest rates charged by the society are supposed to be lower than the commercial bank mortgage lending rates. BBS have long been criticized for being limited in serving the needs of the poor. Kerr and Kwele (2000) argue that BBS has adopted norms that are similar to financial institutions which set borrowing requirements that exclude the poor and low income groups from using their mortgage services.

The provision of housing finance in Botswana has centred almost exclusively on formal-sector initiatives and the government has been instrumental in leading the housing finance for low income people in Botswana. To date the government offers one major source of subsidy to target housing finance for those on low incomes through the SHHA programme. SHHA is the only programme in Botswana that provides housing finance to low income people. However, its unique way of operation - of provision of residential land and housing finance, as well as being responsible for regulating the housing construction - makes it an

exclusive housing finance provider and will be discussed in detail in section 3.5.4 as a scheme for housing the low income people. Consequently, informal methods of housing finance have been outlined to be making a substantial contribution towards meeting low income needs (Datta et al, 1999).

The limited housing finance in a form accessible and affordable to the needs of the poor can be criticized for excluding the poor from home ownership and requires urgent intervention. Mitlin (2007) argues that the recent developments in housing finance for low income people can adopt the following two alternatives to improve access to affordable housing finance for the poor people:

Savings - Low-income individuals often start savings to provide a fund they can draw on to help cope with emergencies or illness and this develops into savings for housing too. The savings programmes could benefit poor people in several ways: it is an appropriate alternative for those who choose to finance improvements through savings rather than taking up loans; it avoids the risk of not being able to meet loan repayments, for those with low and irregular incomes; community-based savings groups help individuals save and holds local people together, enabling them to build the trust and confidence needed to identify collective priorities and implement development projects together.

Housing microfinance -A growing number of microfinance agencies offer small loans for housing development and housing improvements. Microfinance institutions have long observed that low income people often use business loans for housing needs in response to the lack of widespread access to housing finance. This outlines that microfinance has potential beyond income-generating uses (enterprise) and can apply to personal investments such as housing acquisition. Microfinance has loan amounts that are modest; credit terms and conditions that allow the finance provider to afford associated costs (Mitlin, 2007; USAID, 2008). The success of innovative schemes such as the Grameen Bank[24] and micro finance to support the establishment of small enterprises has led many analysts to consider similar models in housing (Datta et al, 1999).

---

[24] Grameen credit is based on the premise that the poor have skills which remain unutilised or under-utilised. Grameen provides credit to the poor, women, and the people who pleaded that they did not know how to invest money and earn an income. Grameen created a methodology and an institution around the financial needs of the poor, and created access to credit on reasonable term enabling the poor to build on their existing skill to earn a better income in each cycle of loans.

Botswana may need to explore such schemes and innovations in order to assist the poor people with access to housing finance.

3.6 SUMMARY

This chapter has outlined that the HIV virus has spread unevenly around the world, and has largely affected parts of Sub Saharan Africa rather than in any other region in the world. The explanation to this variation lies in several epidemiological factors. HIV/AIDS in Africa is predominantly transmitted through heterosexual intercourse and its spread is exacerbated by a combination of socio- economic factors and cultural practices common in African societies. HIV is easily transmitted where condom use and male circumcision are rare, and where ulcerating STIs are prevalent and difficult to manage due to lack of health resources. The lack of resources to purchase coupled with cultural beliefs and norms that are common within the African region. Most countries within the region have affordability problems to treat even the simple sexually transmitted infections which research has reported as amongst the main vehicles for HIV transmission. The estimated high numbers of PLWHA and the modes of HIV transmissions that are prevalent in sub-Saharan Africa have raised some key questions of why the HIV/AIDS epidemic continues to grow in Africa. Several underlying factors have been raised in explanation to this; these include poverty at both household and national levels, as well as the gender inequalities that are widespread among the African communities. The chapter has noted that the impacts of the HIV/AIDS epidemic are more pronounced on socio-economically disadvantaged households. Poor women have been outlined as a particularly hard hit group in terms of vulnerability to infection as well as the effects of the epidemic due to their social, economic and legal disadvantages (Collins and Rau, 2000:19). The chapter has also noted that some economically established countries in the developing world administer the life pro-longing anti retroviral therapy to the infected population. However ARTs have long

---

Grameen gives credit through non-profit organizations or through institutions owned primarily by the borrowers. If it is done through for-profit institutions not owned by the borrowers, efforts are made to keep the interest rate at a level which is close to a level commensurate with sustainability of the programme rather than bringing attractive return for the investors..... Reaching the poor is its non-negotiable mission. Reaching sustainability is a directional goal. It must reach sustainability as soon as possible, so that it can expand its outreach without fund constraints. (http://www.grameeninfo.org/index.php?option=com_content&task=view&id=28&Itemid=108)

term fiscal problems on the national budgets, particularly as many countries are facing economic crisis. Furthermore, ARTs have the potential to increase the prevalence rate of HIV because people taking ART remain sexually active hence a risk group in terms of contributing to the spread of HIV. The chapter gave an insight into the HIV/AIDS situation in Botswana- the case study area- outlining the country as an interesting case due to the contradiction of the HIV situation apparent in Botswana. It is among the countries with the fastest growing economy in the world, but at the same time, it has the second highest HIV prevalence rate in the world and is characterised with socio-economic problems such as unemployment, poverty and gender inequalities. The Botswana government has invested significant resources in the response to the epidemic in terms of putting in place initiatives focused on prevention, treatment, care and support of PLWHA. These include the administration of free anti-retroviral therapy to the PLWHA, which has been reported as successful in terms of reducing the HIV mortality rate and prolonged the life of PLWHA. However it has a potential to increase the number of new HIV infections and consequently raise the prevalent rate of HIV in the country. Furthermore, problems related to the spread of HIV such as, having concurrent sexual partners, lack of male circumcision, gender inequality and stigma and discrimination are still a prevalent in Botswana (Kalichman et al, 2007).

In a nutshell, it can be argued that despite the achievements of Botswana in its national response in fighting the HIV epidemic, housing have been greatly ignored even though there is a growing evidence indicating the importance of housing on health outcomes. It is important to note that there is interplay between HIV/AIDS and other development issues such as poverty and access to basic resources such as shelter and hence the need to integrate housing with health policies and intervention strategies

Literature on the provision of housing in Botswana is centred almost exclusively on formal sector initiatives. The government has been instrumental in leading the housing debate evidenced by that it currently provides much of housing in the country. Such governmental interventions can be argued to have the potential to prevent the development of a thriving housing market. The recognition and support of the informal housing initiatives is important and could benefit the housing market in Botswana. This could not only encourage the development of the informal housing market as an instrument of poverty alleviation for low income people but could ultimately improve the poor housing

conditions prevalent in the informal housing hence provide housing that will be of health benefit of the people using it.

Through exploring the literature that relates housing to health, examining the Botswana national housing policy and scanning through the housing delivery programmes, it has been possible to identify a number of areas that remain under explored. These gaps form the basis of the research agenda for this thesis: acknowledging housing as a social determinant of health through exploring the experiences and situations faced by PPLWHA in the urban housing market of Botswana. Before presenting the empirical analysis of this research, the next chapter will explore how the research was conducted.

CHAPTER 4: METHODOLOGY AND METHODS

4.1 Introduction

The aim of this chapter is to explain the methodological approach of the empirical study. The chapter examines the methodological and theoretical framework used in carrying out a study which conceptualizes HIV/AIDS as a problem in housing for poor people living with HIV/AIDS. The intention of the chapter is to present the researcher's position on the problems under investigation through discussing how knowledge of the problem was gained and the manner in which the study was conducted. The chapter is divided into 12 sections outlined as follows:

Section 4.1 is this introductory section that outlines the structure of the chapter.

Section 4.2 is the presentation of a detailed description of the research aims and research questions. It gives a justification on how the sub-questions derived from the main research questions have been used to assist in the designing of the data collection instrument, specifically the interview guides.

Section 4.3 presents and justifies the theoretical stand-point of this research. It starts by exploring the various theories used in housing research giving a justification of why each of them is unsuitable for this study before contending critical realism as the useful framework for exploring the reality of HIV/AIDS, poverty and poor housing on PPLWHA.

Section 4.4 continues to discuss the methodological framework giving emphasis to the case study research method used to collect data as well as a justification of the actual processes the researcher was involved in before, during and after the data collection process outlining the problems encountered in each stage of the process.

Section 4.5 presents a discussion of issues of negotiation of access to the study areas including the study subjects outlining the challenges encountered and how they were addressed at each stage of negotiating access. Section 4.6 builds on this to discuss the

ethical issues that need to be observed, particularly as the study deals with the sensitive issues of HIV/AIDS.

Section 4.7 discusses the sample population, presenting the sample size and giving a summary and justification of the selection of the participants who were in the sample for the study.

Section 4.8 presents the data collection methods and techniques, emphasising the use of semi-structured interview which was the primary data collection tool used before going on to discuss the process of transcribing and translating the data from the local language to English.

Section 4.9 and 4.10 adds to the study the other sources of data used including observation and other secondary data documents to support the primary data collected through interviews.

Finally, Section 4.11 describe the data analysis process, often giving justification for adopting the techniques used, challenges encountered, and the likely effects of the data analysis process adopted on conclusions made by the study.

In conclusion, Section 4.12 gives a summary of the discussions of the chapter.

4.2 Statement of Purpose

The primary aims of this research are twofold: firstly, is to analyse the impact which HIV/AIDS has on housing for the poor and the low income people in Gaborone City through exploration of housing related problems and constraints faced by the poor people directly affected[25] by HIV/AIDS, as well as their response to the difficulties and problems at both an individual and family level. Secondly, is to analyse the intervention mechanisms planned and implemented through the national housing policy and by other housing and related stake holders in response to the housing difficulties for PPLWHA at community and national level.

---

[25] For the purpose of this study, people who are directly affected by HIV/AIDS refer to those that are infected by HIV, AIDS patients and their immediate family members.

4.2.1 Objectives of the Study

In order to achieve optimum results from limited resources of time, finance, and data sources, it was imperative to begin work on methodological approach by identifying the type of information that would be required in order to adequately answer each of the main research questions. To achieve this, a series of specific sub-questions, many derived from the literature review and others based on the researcher's own experiences and discussions with colleagues were raised. These are listed below under each key research question:

Research question one: What are the socio-economic, environmental, and physical and health problems and difficulties experienced by the poor people living with HIV/AIDS in their housing in Gaborone?

Sub Questions:

1. How do the PPLWHA in Gaborone describe their housing experiences, conditions and situations?
2. What problems and difficulties do the poor people living with HIV/AIDS perceive and experience in Gaborone?
3. What are the circumstances[26] surrounding housing for poor people living with HIV/AIDS in Gaborone?

Research question two: How do the poor people living with HIV/AIDS respond at personal level in an endeavour to cope with their housing problems and difficulties?

Sub Questions:

1. How do the poor people living with HIV/AIDS cope with their housing situations in Gaborone?
2. What kind of activities do PPLWHA engage in, in response to their housing needs at household level?
3. In what ways do these activities that the PPLWHA adopt in response to their housing need contribute to and or impact on their health and wellbeing?

[26] Circumstances will include but not be limited to causes, facts, information, events and conditions influencing housing for poor PLWHAs.

Research question three: What underlying factors and/or structures are apparent to the different housing stakeholders; hence having an influence in the response to the housing problems and difficulties faced by PPLWHA?

Sub Questions:

1. What socio-economic factors and/or structures (in exception of illness) are apparent in the lives of poor people living with HIV/AIDS that may or may not be contributing to their housing problems and difficulties?
2. How do the social welfare system and other related institutions address the issue of housing the poor people living with HIV/AIDS?

Research question four: What intervention strategies have the lands and housing policy makers and other housing stakeholders put in place in response to lands and housing problems and difficulties faced by poor people living with HIV/AIDS?

Sub Questions:

1. How does the government through its welfare policies intervene in response to the housing needs of PPLWA at national level?
2. How have the aims of the national lands and housing policy being affected by the HIV/AIDS epidemic and how have they been altered to accommodate/respond to the impact of the pandemic?
3. What intervention strategies are specifically designed by the government to address the lands and housing needs of the vulnerable groups?
4. How do these interventions promote or hinder housing for poor people living with HIV/AIDS and their dependants?
5. How effective are these intervention strategies that have been designed and implemented to meet the housing needs of the poor people living with HIV/AIDS?

The exercise of developing the sub-questions was beneficial because it contributed to focusing the thinking process on data collection and facilitated early decisions on data collection strategies. Working through research questions and sub-questions led to the identification of a number of data sources and basic methods of data collection: semi-structured interviews for primary data and published and unpublished sources for

secondary data. Developing sub questions also led to the idea of classifying the interviews into four different groups involved in housing delivery for this study: housing policy makers, housing service providers and housing consumers including poor and low income people living with HIV/AIDS and those indirectly affected by HIV/AIDS. Furthermore, the sub questions formed a basis for preliminary drafts of data collection instruments being the interview schedules for the three different groups included in the study.

4.3 Theoretical Framework

This section presents the theoretical and methodological issues underpinning the study. It begins by setting out briefly the importance of theory in research before proceeding to discuss the theories that are commonly used to guide housing research. Subsequently, the discussion will continue to contend that critical realism provides a useful theoretical framework within which to advance the understanding of placing HIV/AIDS epidemic as a problem that contributes to the housing problems and difficulties faced by poor people infected and directly affected by the epidemic, as well the policy makers in addressing the housing problem for the poor people.

4.3.1 Overview of Theories Used in Housing Research

In any academic discipline, scientific inquiry is conducted within a specific theoretical framework. A theory is a collection of interrelated concepts which guides the research, determining what things the researcher will measure, and what statistical relationships will be looked for from the study. Theory is important in research because

> "It helps in understanding of the way that concepts relate together and help to understand why something is as it is or why something happens." (Clapham, 2009:5).

Furthermore, Borghatti (1999) argues that theory helps the researcher make logical sense of the relationships of the variables and factors that have been deemed relevant/important to the problem under study.

According to King (2009), theory in housing research has developed considerably since the early 1990s with the general ambition of application of theory to housing issues rather than the creation of new theory. This has been found to be useful as it helps 'test the theory's utility' as well as improving understanding of housing issues. Contemporary housing

research has now developed a willingness to draw upon explicit theory from the different social science disciplines (Jacobs et al, 2004).

This section will briefly discuss theories that are commonly and popularly applied to guiding housing research. The assumptions as well as strengths and limitations of three main theoretical paradigms, namely positivism, interpretivism and feminism will be briefly discussed to aid their understanding as well as justify their unsuitability for this study. However, there is an extensive amount of literature readily available from numerous sources for an extensive understanding of these theories.[27]

When discussing theory and/or philosophy, it is fundamental to consider the epistemology and ontology that provide the framework for defining the nature of knowledge for the theory adapted for the study problem. Epistemology deals with the theory of knowledge. Bryman (2004, p.539) describes epistemology as a stance on what should pass as acceptable knowledge and the conditions for acquiring it. Similarly, ontology is concerned with theory of existence. Ontology seeks answers to questions regarding social reality or the nature of being – unravelling, for example, what actually exists as opposed to what appears to (but does not) exist (Mason, 2002; Musole, 2007). Both ontology and epistemology are important in inquiry, especially for defining the methodology; which basically represents a set of rules, procedures and techniques for indicating how arguments and research are carried out within specific disciplines. The potential data sources and/or methods of generating relevant data both depend upon and assist in expressing the research's epistemological and ontological positions (Crossan, 2003).

There are several theories that are recognised and employed by researchers in housing and social science that will be briefly critiqued in turn below in justification of why the study adopted the critical realist perspective to advance the understanding of recognizing HIV/AIDS epidemic as a problem that contributes to housing problems and difficulties faced by PPLWHA and a challenge to the policy makers in addressing the housing problem for the poor people.

[27] Material on which this section was derived came from multiple sources, including, Lawson (2006), Sayer (1992) Fitzpatrick (2005), Bryman (2004), McKechnie (2007), Lewis (2001) and William (2009)

The summary in Table 4.1 below will briefly consider the ontological and epistemological assumptions as well as the strengths and weaknesses of some theories used in housing research. This will assist in an understanding of the research methods' theoretical foundation as well as in justification of the researcher's adoption of the critical realism theory for this study.

Table 4.1: Philosophical traditions - a summary of main features, strengths and weakness

Approach	Epistemology	Ontology	Methodology	Strengths	Weakness	Suitability to use in this study
Empiricism	Knowledge is gained through experience and senses	Reality exists in that which is experienced	Presentation of the experienced facts after they have been collected, ordered and presented objectively as empirical facts	Descriptive power affords the ability to account for observed phenomena; handles both empirical and normative questions.	Descriptions lacks explanatory and analytic power; unscientific approach; ignores power relations in society.	Understanding the housing challenges for poor PLWHAs' needs a perspective that not only observes the phenomena but explores the structures and mechanisms through personal accounts which is lacking in the empiricism approach.
Positivism	Knowledge is acquired through agreed verifiable evidence of empirical facts.	Reality is present in appearances, but is independent of the observer	Verification of factual statements, using scientific method and other quantitative and statistical techniques based on hypothesis testing	Facilitates the testing of hypotheses which provides the basis for the development of laws and theories; empirical data and replicable research methods advance explanation	Creates false sense of objectivity; exclusion of human objectives and decisions; quantitative techniques, filter out social, aesthetic or moral issues; mechanistic framework content with surface appearances only; ignores power relations and conflict in society.	Exploration of housing challenges faced by poor PLWAs' is subjective and inclusive of many other factors and actors that need extensive qualitative inquiry to unearth the unobservable underlying structures (such as politics, debates, powers, economies, social practices) contributing to the observable.
Interpretivism	Knowledge is intentionally and subjectively constituted through a person's lived experience	Reality exists in how people interpret the world around them. Person and reality are inseparable	Generation of theory from descriptions produced from social accounts using case studies, observations, ethnographic studies and phenomenographic studies.	Constructs social scientific accounts of social life by drawing on the concepts of meaning used by social actors; generate theory using descriptions produced from social actors' accounts	Ignores the role of social structures that both condition and produces social interaction, particularly divisions of interest and relations of power; social actors may be either partially or completely unaware of	Social structures and mechanisms (such as patriarchy, poverty, power relations, socio-economic traditional beliefs and customs) form a crucial part in the housing challenges faced by poor PLWHAs'.

					structures.	Using this stance will overlook these important structures hence fail to deal with the causal explanation that the study seeks to identify. This study requires some degree of perception which may not be easily reduced into hard facts hence the need for rigour, precision, logical reasoning and attention to evidence without being confined to only what can be physically observed.
Feminism	Knowledge is constructed subjectively through women's accounts of their lived experiences	Reality exists in that which is experienced and lived by women	Generally subjective through the use of case studies, participant observation, use of various types of questionnaires and interview techniques (collectively referred to as qualitative methods)	Provides an account for improved social relations and change through empirical analysis of gender inequalities that aim to promote and empower women.	Vulnerable to bias as it is predominately concerned with gender sensitive analysis of social aspects of science , inequalities for women opposed to men; pays little or no attention to space and time	HIV/AIDS is not gender sensitive and this study seeks to capture the accounts of housing challenges from balanced and inclusive perspectives. Excluding male participants will therefore overlook the crucial life accounts of how the structures and mechanisms affect and are affected by male living with HIV/AIDS hence produce biased findings.

Source: Adapted by author from Musole, 2007, p.128

It will be useful for this study to focus further on two of the major approaches (positivism and post-positivism) that are especially important for guiding housing research but not particularly suitable to guide this study.

a. Positivism

As summarised in Table 4.1, Positivists perceive the world as all that is observable. It is based on the ontological position that objective reality is present in appearances and that it exists independent of observers and is, therefore, not a creation of human mind. They argue that reality is defined by the meanings given by its inhabitants rather than any objective, independent researcher. Consequently, positivist approaches assume that things could be studied as hard facts and the relationship between them can be established as scientific laws capable of verification by empirical analysis (Crossan, 2003; Musole, 2007).

Positivism and empiricism offer easily accessible and objective methods (for example, quantification and statistical methods). Fitzpatrick (2005) contends that positivists traditionally adopt theory of cause and effect which focuses on the search for observable 'empirical regularities' that has statistically significant correlation between variables.

The epistemological stance of positivism is that knowledge is gained from experience, and that this experience should be firmly established as verifiable evidence on which all those working in a specific field would agree. It argues that only that which is directly observed and measured can be accepted as evidence. Referring to Roy Bhaskar's[28] criticism of positivism, he suggests that believing that an event can be understood through repeated empirical observation is an 'epistemic fallacy'; positivists hold a view that people can only know that which they experience and/or perceive through the senses and scientific knowledge can yield true and correct connections between ideas and reality (Bhaskar 1986, quoted by McKechnie, 2007).

In their argument, positivists in housing research contend that housing systems are perceived as a complex of social relations and are expressed in terms of directly observable

[28] Roy Bhaskar is widely regarded as the founder of the critical realist movement.

and measurable variables which can be statistically analysed. However, other researchers argue that studies with the aim of examining and explaining underlying mechanisms (such as this study) cannot use the methods of positivism as these simply reflect the everyday world, not the conditions which make it possible (Fitzpatrick, 2005).

The positivism highlighted above has important implications for natural sciences and social research. Clearly, it can be discerned that a positivist approach lacks the means to study human beings and their behaviours in an in-depth and meaningful way (Crossan, 2003). For example, rigorous investigation about human attitudes, feelings and perceptions cannot be carried out through the positivist approach. Consequently, an alternative paradigm commonly known as post-positivism[29] emerged to embrace these shortcomings.

b. Post- positivism

The epistemological position of post–positivism is that human knowledge is not based on unchangeable, rock solid foundation; it is abstract (Musole, 2007). For that reason, knowledge can be acquired by means of both induction and deduction. Ontologically, as observed by Crossan, (2003), it is held that reality exists in a vacuum, it is influenced by context and many constructions of reality are possible. Reality can therefore be summarised to be subjective, contextual and mentally constructed. Post-positivism approaches assume that among the various factors that influence reality construction are individual behaviours, attitudes, external structures and socio-cultural issues.

Similar to other approaches, post-positivism has its weaknesses and strengths. Notably, the post-positivist approaches are criticised for their lack of generalisability as people being studied vary in terms of perspectives, background and even experiences and cultures. In addition, post-positivism is not particular about the sample size and representativeness of the sample as positivists typically are.

However, supporters of post-positivism assume that its strength lies in the use of flexible, multi faceted methods (both qualitative and quantitative) to the study of phenomena (Trochim, 2006).

[29] Post-positivism philosophies include phenomenology, critical theory, post structuralism , Marxism and post modernism

It is important to acknowledge that post-positivism is not a slight adjustment to or revision of the positivist position. As Trochim (2006) observed, post-positivism is a complete paradigm shift from the positivist school of thought rejecting the central tenets of positivism.

In a nutshell, it can be concluded that positivism adopts a clear-cut quantitative approach to investigation of phenomena while post-positivism seeks to describe and examine phenomena in depth from, but not exclusively, a qualitative perspective.

As already noted, post-positivism embraces a wide variety of philosophical stances including constructivism, phenomenology, and critical theory, post structuralism, Marxism and post modernism. However, this study will principally discuss realism as it is argued that it underpins this study.

4.3.2 Theoretical Basis of This Study

The above brief review of philosophical issues in general provides a basis on which the philosophical orientation of this research can be established. As already outlined, this study is concerned with the housing challenges faced by PPLWHA and responses they get from the policy makers and the housing providers. Arguably, a number of issues under discussion in this study are likely to be unobservable (for example the political power relations, influence and authority involved in the provision of housing as a social need for PPLWHAs') but yet obviously significant in the social life of the people under study. The study of such nature therefore requires some degree of perception which may not be easily reduced into hard facts and hence the need for rigour, precision, logical reasoning and attention to evidence without being confined to only what can be physically observed. This study therefore shares the ontological and epistemological perspectives of the post-positivist approach; and especially critical realism to be discussed in turn below.

However, the brief review in this section cannot offer a detailed clarification of critical realism or its theoretical underpinnings (For a detailed discussion of the epistemology see Archer *et al,* 1998; Sayer, 2000; Bhaskar, 2002). The section will start by briefly summarising the assumptions and beliefs of critical realism. It will proceed to link it to this study giving justification for choosing it over other perspectives. Special emphasis will be on the realist's contention that reality is not merely observable, but comprises several

interconnected domains: the real, actual and empirical domains, which will be defined later in the chapter.

a. Defining Critical Realism

Critical realism is an epistemology that challenges the researcher's view that only that which is observable exists. The goal of realist research is explanation- utilising a comprehensive and defensible conception of what is real and compatible modes of reasoning, with the goal of revealing empirically feasible explanatory casual mechanisms. Critical realism not only acknowledges the existence of socially constructed experience but also actual physical and non physical conditions, actual events and influential social relations (Lawson, 2006).

In adopting a critical realist perspective, it is important to spell out some key claims and characteristics that one of the key theorists of critical realism, Sayer (2003), has outlined.

1. The world exists independently of our knowledge of it.
2. Our knowledge of the world is fallible and theory laden. Concepts of truth and falsity fail to provide a coherent view of the relationship between knowledge and its object. Nevertheless, knowledge is not immune to empirical check and its effectiveness in informing and explaining successful material practice is not mere accident.
3. Knowledge develops neither wholly continuously, as the steady accumulation of facts within a stable conceptual framework, nor wholly discontinuously, through simultaneous and universal changes in concepts.
4. There is necessity in the world; objects – whether natural or social - necessarily have particular causal powers or ways of acting and particular susceptibilities.
5. The world is differentiated and stratified, consisting not only of events, but objects, including structures, which have powers and liabilities capable of generating events. These structures may be present even where, as in the social world and much of the natural world, they do not generate regular patterns of events.
6. Social phenomena such as actions, texts and institutions are concept-dependent. We therefore have to read and understand their production and material effects as well as interpret their meaning. Although they have to be interpreted by starting from the

researcher's own frames of meaning, by and large they exist regardless of researcher's interpretations of them.

7. Knowledge of reality is to be found beyond the concrete and the observable since the world of the social is composed of agents who are continually constructing and deconstructing their world and their acts within the world.

Critical realism distinguishes between the world of nature and the world of the social. For realists, social science is a demanding undertaking because it requires not only the description of social relations and events but also a commitment to explaining them by means of uncovering hidden dimensions of social reality (Fitzpatrick, 2005).

Realists argue that the knowledge people have of their social world affects their behaviour and unlike the propositions of positivism and empiricism, the social world does not simply exist independently of this knowledge. Given this, causes are not simply determining of actions, but must be seen as tendencies that produce particular effects. People's knowledge may be partial or incomplete, but to a critical realist all knowledge is fallible although not equally fallible. The task of the social researcher therefore is not to simply collect observations but to explain these within a theoretical framework which examine the underlying mechanisms which inform people's actions and prevent their choices from reaching realization (May, 2001).

b. Causal powers in critical Realism

One of the most distinctive features of realism and relevant to this study is its analysis of causation. For a basic understanding of the concept; causation is about what produces change (the activation of causal powers) not about (whether observers have registered) a regular conjunction of cause events and effect events. Hence, regularities are not necessary for explanation, whether of physical or social phenomena. Even where we do find regularities, they still have to be explained in terms of what produces them (Fairclough, et al 2003). For example, this study hypothesises from observation that PPLWHA's live in poor housing conditions. However, there is a need for a clear understanding of the causes, effects and relationship between the other structures, mechanisms and events (observable and non observable) that cause and or facilitate the problem of poor housing for PPLWHA's in Gaborone. The use of causation which is known to promote the

consideration of underlying social relations and causal mechanisms generating social practices, ideological constructs, and perceived phenomena will therefore benefit the study in that aspect.

In critical realism, causation challenges the understanding of the complex, dynamic and structured nature of the research under study in attempt to propose, refine and offer practically adequate explanations for continuing critique and development (Lawson, 2006; Bryman 2004). Critical realism contributes most forcefully its focus on the concept of causative powers as well as the ethical principles and procedures for drawing value from facts. To the realist, causal powers are necessary tendencies of social objects and structures which may or may not be activated and produce 'actual' effects depending on conditions (Sayer, 1992). In addition, Lewis (2001) outlines that for critical realists the unobservable entities can be known to exist through their impact on observable events.

Methodologically, it is important to note that the central hypothesis, that housing challenges for PPLWHA in Gaborone may be generated by the interaction of social, political and economic structures and not solely their health condition, presupposes causality. Therefore the use of critical realism's two modes of inference[30] that Lawson refers to as the 'backbone of realist inspired methodology': abduction[31] and retroduction[32] are fundamental to confirm or reject the central hypothesis of the study. However, it is important to note that although this approach (abduction and retroduction) doesn't necessarily give what Sayer (2003) refers to as a 'royal road to the truth', ontologically, it provides a more fruitful pathway to progress in causal explanation.

---

[30] A critical realist explanation doesn't involve deduction or induction but rather abduction and retroduction.

[31] Abduction involves the interpretation and re-contextualisation of phenomena to be explained, using a competitively plausible set of explanatory ideas and concepts to produce a new interpretation (Lawson, 2006). Abduction can help develop a broader, deeper knowledge by building on creativity and imagination.

[32] Retroduction follows abduction, moving from the new descriptions to abstract tendencies that cannot be directly observed, using thought processes (Lawson, 2006). Retroduction involves advancing from empirical observation to arrive at something different. It requires that the researcher construct a hypothetical model that if it were to exist and act in the anticipated way, would account for the phenomena in question. The retroduction process helps in revealing structures and mechanisms, and assessing their relations and effects. This process may produce emancipation by revealing the structures and mechanisms in function.

A realist thus starts with an empirical problem and proceeds to abstract the necessary relation between the concrete phenomenon and deeper causal structures to form generative mechanisms (see figure 4.1 for details).

It is crucial to acknowledge that causal structures are multi-faceted and complex, with numerous mechanisms coming together to create an event. Some mechanisms may act in a complementary fashion, others in opposition to one another. Thus the same mechanism may produce different outcomes depending on the existence of other mechanisms. By recognising the existence of multiple mechanisms and multiple structures, it becomes possible to avoid charges of reductionism and move away from a positivist 'cause and effect' model of causation and adopt abduction and retroduction approach.

Although housing problems that are faced by poor people living with HIV/AIDS are believed to be generated by the interaction of complex socio-economic structures including poverty, unemployment, and lack of social welfare as well as cultural structures such as gender inequalities and patriarchy among the affected people, these factors need to be explored and be related to each other through rigorous investigation. Following the methodological assumption of critical realists, qualitative data collection methods focusing on experiences and meanings of individuals, as captured by interviews and cases of life stories, are deemed acceptable although such phenomena are not observable.

The study will be based on and directed by the realist's contention that reality is not merely observable, but comprises several interconnected domains: the real, the actual and the empirical domains. As outlined above, the concept of causation is of crucial importance to this study hence it will be adopted to explore the structures and mechanisms that are apparent in the housing challenges of PPLWA. Critical realists acknowledge that we operate in the domain of the empirical but cannot ignore the structures and the mechanisms of the 'real' manifested in the 'actual' as explained in turn below.

The real

The 'real' domain consists of process, structures, powers and causal mechanisms that generate events. In the real of the challenge, there is an intrication of experience, fact, value, representation and action. For some real issues, reality is expressed in a form of soundless utterance and in such cases no accommodation to what exists can be made.

As it is evident in this study, HIV/AIDS and poverty are real phenomena that are undoubtedly a challenge in the lives of the poor PLWHAs. However, there are other social, economic and political structures and mechanisms that are interconnected with HIV/AIDS and poverty to put more pressure on housing for affected people.

The real can be described in terms of its structure of causative powers. As Williams (2009) contends, real things have causal properties although some objects possess greater causal efficacy than others. However, in any real situation, there is usually a complex combination of relationships that needs to be unpacked. For instance, as Lawson (2006) noted, real risks in housing are usually concentrated amongst those households with fewer and less secure monetary resources and have emerged from important changes affecting property, savings, and investment, labour and welfare relations.

The actual

The 'actual' domain of reality relates to activation of events which may be either observable or non-observable. These events are generated by real underlying mechanisms or structures, which tends to have influence in favourable circumstances (Bhaskar, 1975). The actual refers to what happens when the (real) powers and liabilities are activated and produce change. Furthermore, as Fitzpatrick (2005) observed realist explanation of actual social events and phenomena are not 'mono-causal' and deterministic but are rather:

- 'Complex' with loops linking multiple causal mechanisms.
- 'Emergent', because from this complexity of new properties may emerge more new properties which may not be inferred from individual components.
- 'Non linear', because small changes in these complex relationships can bring about sudden and dramatic outcomes.

Considering the above explanation, it can be argued that the presence of other causal mechanisms may often or even always prevent correspondence between cause and effect, which is why the presence (or absence) of empirical regularities is not a guide to the non-existence of 'real' causal powers in realism.

The Empirical

The 'empirical' domain involves experiences and events through observation. It gives opportunity to explain any observable effects at this level with reference back to the underlying unobservable structures. Empirical experiences can influence behaviours hence what happens, much of the social and physical worlds can exist regardless of whether researchers and in some cases other actors are observing or experiencing them.

Critical realism distinguishes the real from the actual and the empirical. In his thesis, McKechnie (2007) devised a three dimensional framework to explain how the real, the actual and the empirical interact to produce the experience as discussed below in turn for a basic clarification;

Figure 4.1 below aims to show the structures of society[33] and agency[34] that give rise to particular generative mechanisms and events which interact to produce a specific experience.

[33] Society refers to practices and conventions which individuals reproduce or transform.

[34] Agency refers to properties irreducible to matter, including properties which emerge from persons which are reducible to society.

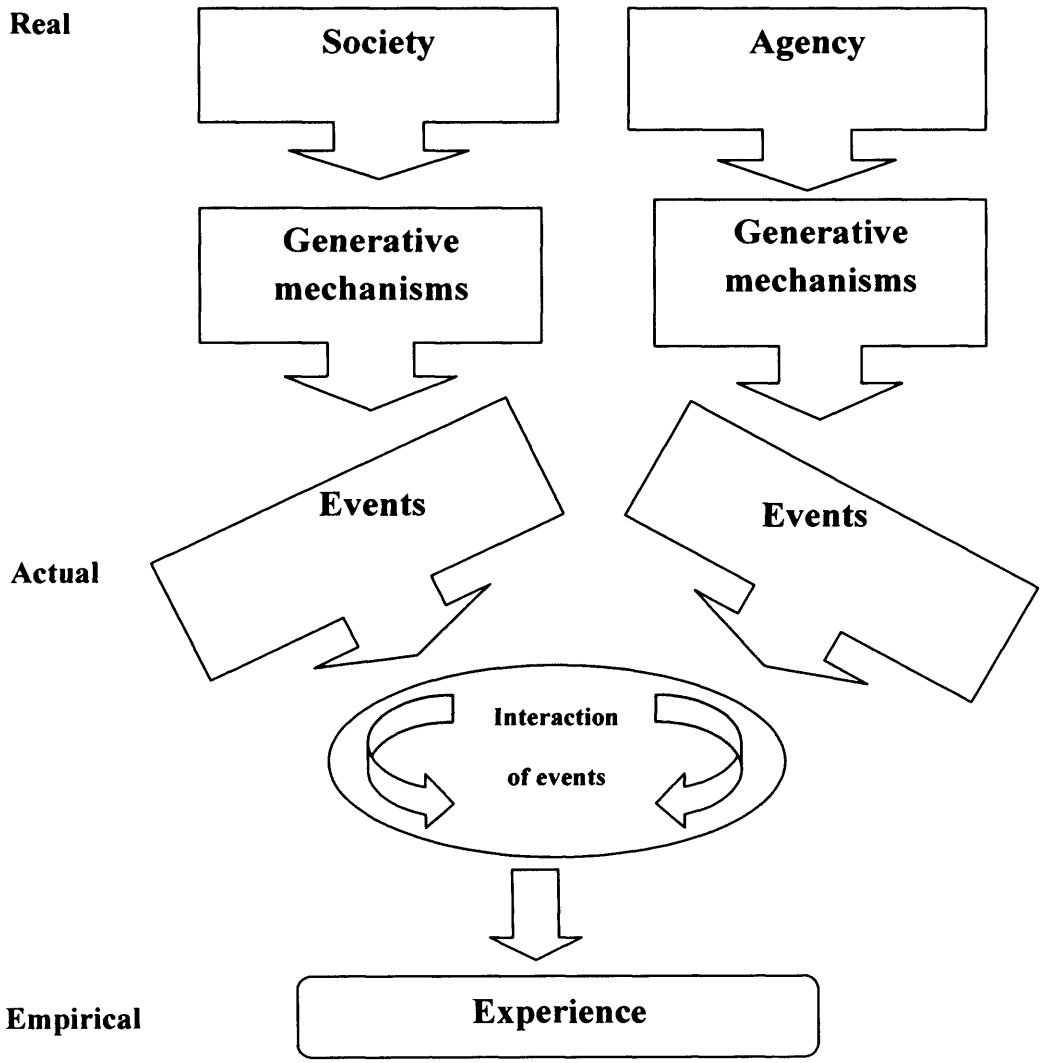

Figure 4.1: Framework for explanation of an experience

The top layer comprising the agency and society describes the real. Lewis (2001) outlines that at the core of the critical realist analysis of the socio-economic world lies its account of the relationship between the social structure and human agency. Each of the structures in the real gives rise to particular generative mechanisms which also exist at the level of the real. It is of importance to note that there could be a number of mechanisms arising from any one structure.

People constantly draw on these social structures in order to act and in acting they either reproduce or transform them. The structures and their emergent generative mechanisms at the level of the real give rise to particular events at the level of the actual in the middle of the diagram. It is also important to note that there could be a number of events arising from specific structures and generative mechanisms that interact at the level of the actual.

At the very end of the diagram, there is the empirical level: that is where the observable experience emerges. The result of the interaction (at the level of the actual) leads directly to a particular experience (at the level of the empirical). In a nutshell, the experience is a result of the interaction of events which arise from structures and their emergent generative mechanisms. However, the experience may be temporarily located and changed over time. The temporality of the structure-agency relationship becomes apparent when we recognise that all human activity takes place within the context provided by a set of pre-existing social structures. Lewis (2001) observes that at any given moment of time, people confront structures which are pre-formed in the sense that they are the product, not of people's actions in the present, but of actions undertaken in the past. These structures include not only big social, political and economic objects but also include small ones at the interpersonal and personal levels (Sayer, 1992). However, in a nutshell as observed by McKechnie (2007), the objective of critical realism is to explain the experiences and events by identifying the underlying structures and causal mechanisms responsible.

c. Housing problems faced by PPLWHA from a realist perspective

Research evidence may demonstrate that a recurring pattern of events and circumstances increase the risk of the housing problems and difficulties for PPLWHA rather than those events and circumstances being the causes. Such an increased risk approach undoubtedly has value at the descriptive level in that it appears to be empirically well-grounded.

However, it is unsatisfactory at an explanatory level with regard to causation. There is therefore a need to understand why the outlined structures lead to an increased risk of the housing problems faced by PPLWHA. Realism is capable of providing a resolution to this problem. It supposedly reinstates these 'risk factors' as real causes of the housing problems and difficulties if the outlined risk factors can be shown to have a tendency to bring about the housing problems under discussion.

In identification of housing problems and constraints faced by poor people living with HIV/AIDS, critical realism is used to recognize the underlying reality beneath the structures that are asserted to cause the problems. It contests that there are structures that have 'a real' existence, whether or not they are defined as constituting housing poverty for PPLWHA. Using the realist theory, focus will be placed on rigorous abstraction of the underlying complex structures that are apparent in order to identify and define necessary tendencies which may constitute causal mechanisms.

The critical realist's notion of causation will be adopted to help explore and clearly define the observable and unobservable structures and mechanisms that have the potential to influence the problems faced by PPLWHA. Lawson (2006) states that in a need to better understand the process generating social problems, it is appropriate to argue for more relevant strategies addressing the generative causes rather than merely tempering the symptoms. Based on this contention, it is neither sufficient nor effective to be concerned about the symptoms of housing problems and difficulties among the poor people living with HIV/AIDS without realizing the generative causes.

As Lawson (2006) noted, housing is a reality which only exists in terms of observable measurable events. Most of the studies on HIV/AIDS and housing provide statistics, facts and figures but don't give account of affected peoples' lived experiences and housing conditions. Studies that have personal accounts from PPLWHAs usually discuss health related issues with particular emphasis on modes of transmission of the disease and response to medical treatment. However, this study, that needs to search for underlying causal mechanisms of difference and change in housing systems need to be guided by critical realism; which is committed to search for generative causes among structured, complex and open phenomena through the use of the case study method.

Upon taking the critical realist standpoint, this study will be directed by a few central tenets of critical realism which are observed by Sayer (2003). The key assumption of critical realism is that the world is stratified into three distinct ontological domains: the empirical (experiences), the actual (events) and the real (deep underlying level of structures and mechanisms). The objective in critical realism is to attempt to understand the underlying mechanisms and structures at the level of the real in order to explain experiences. For instance, in this study poverty and HIV/AIDS are real and clearly apparent on the daily lives of PPLWHA in Gaborone hence they are evidently concentrated in areas characterised with poor housing conditions. However, empirical observations cannot in themselves identify the mechanisms behind an observed pattern. Critical realists assume that the unobservable have existence and are capable of explaining the functioning of observable phenomena. As Sayer (2000: 14) explains, the number of times that we can empirically observe an experience or event does not help us to understand what causes it. Rather, to discover and conceptualise the complex range of underlying mechanisms in effect, it is therefore important to engage in intensive research which uses a data collection method that seeks not only to understand concrete data but also assists in identification of causal relationships. This will be beneficial to understand underlying structures and mechanisms. Based on this contention, this study adopted the case study approach which will be discussed in detail in section 4.4. In addition it was guided by the realist assumption that knowledge of reality is to be found beyond the concrete and the observable since the world of the social is composed of agents who are continually constructing and deconstructing their world and their acts within the world.

Therefore, the study involved four different categories of role players outlined in-turn below: all who are hypothesised to have causal powers and hence make a contribution in understanding the structures and mechanisms responsible for the housing problems faced by PPLWHA.

1. **Housing policy makers, who are responsible for housing policy planning and supervision of its implementation.**

   The issue of poor housing for vulnerable people can be argued in relation to economic problems and political decisions regarding the allocation of public funds and social programs (Daly, 1996). Therefore in order to understand the political

nature and complexity underlying the housing challenges faced by PPLWHA, it is necessary to solicit opinions and views of various officials involved in the making and implementation of lands and housing policies as well as socio economic decisions regarding provision of housing and related resources for all citizens (including PPLWHA) in the country. It is of great importance for this study to have an analysis of the political power relations, influence and authority involved in provision of housing as a social need for poor people.

2. **Housing service providers, who are responsible for the implementation of the housing policy aims.**

   In order to obtain the depth of information necessary to expose underlying socio-economic structures and mechanisms in the housing market, a separate but related sphere of housing and related service providers including those responsible for housing, mortgage and property insurance provision was established. This category assisted to make an exploration and analysis of the housing market conditions in which the poor in general and PPLWHA especially have to participate in pursuit of their housing needs despite their health and socio-economic ability. Inclusion of this group assisted with establishing the network of the underlying structures and mechanisms that could be interlinked to answer the questions related to how, where, and why there have been barriers blocking the desired response, reaction and support of housing for PPLWHA if any.

3. **PPLWHA (directly affected by HIV/AIDS) - the end users of the housing services**

   The environment in which PPLWHA live may seem to be characterized by disorder and chaos from observation. In reaction to situations and while attempting to satisfy their basic need for shelter some of PPLWHA may engage in what appears to be self-destructive behaviour to the casual observer. Some of the coping and survival strategies of housing for PPLWHA may be regarded as risky, spontaneous, random and even bizarre from the point of view of an observer. Therefore, as a researcher, in order to describe and define this reality, there is a need to have a more open, contextual and dynamic conceptualization of the situation. Personal life experiences

from PPLWHA can in this sense help to draw out in-depth accounts and capture previously unexplored viewpoints, some of which may be socially oriented such as tradition and cultural beliefs, practices such as patriarchy and other social experiences embedded in culture and tradition. In addition and in concurrence with critical realism, this approach is helpful in revealing the underlying structures and mechanisms at play in the housing challenges faced by PPLWHA in a way that statistical extensive quantitative data could not (Lawson, 2006; McKechnie, 2007). As already noted, causality cannot be understood by how often a mechanism can be empirically observed; therefore an intensive qualitative method such as life experience interviews are most appropriate and particularly useful in investigation and analysis of the issue from the principal source.

4. **Poor people indirectly affected by HIV/AIDS who are also the consumers of the housing services.**

   Separate but closely related, involving the poor people who are indirectly affected by HIV/AIDS provided insights from the people who are not infected by the virus but affected as they similarly use and operate under the same structures and mechanisms as PPLWHA.

In conclusion, this section simply adopts the critical realist ontology arguing that such a perspective can provide more fruitful pathways to progress in causal explanation of housing challenges and constraints faced by PPLWHA through intensive research to understand the connected relations generating dominant facts and housing events. Borrowing from Lawson (2006) who argues that much of the empirical work has been done and now there is a need for causal explanations and as already mentioned, the study adopted the case study approach to collect empirical data that seek this causal explanation.

4.4 Research Strategy: Case Study Research

Bloor and Wood (2006) define case study research as research that aims to understand social phenomena within a single small number of naturally occurring settings, further describing it as an exploration of a 'bounded system'. Similarly Yin (1984) describes a case study as an empirical enquiry that investigates a contemporary phenomenon within its real life setting and where the boundaries between the phenomenon and the context are not

clearly evident. Furthermore, Hamel et al (1993) defines case studies as in-depth investigations of particular cases. All the aforementioned definitions of case study research are useful to adopt for research such as this; that seek to investigate cases in considerable depth and out of naturally occurring social situations.

Although case study research is believed to be a good way of investigating naturally occurring cases and allows for a holistic investigation of real-life events, there are some limitations to it as well. Yin (1994:2) points out that the principal criticism of case-study research has been the inability to provide a basis for generalisation as compared to survey research, where a sample readily generalises the findings to the larger population. Nonetheless, Gomm et al (2000: 5-6) have outlined some methodological issues in support of use of case studies which are also important to this study as briefly discussed below in turn to give an understanding of adopting case study method for this research:

1. **Generalizability** – Although there is some case study work that aims to draw or provide a basis for drawing conclusions about members of a wide population of cases, it is important to note that case studies do not represent a sample; their aim is not to enumerate frequencies or to make statistical generalisations but rather to expand and generalise upon theories or make analytical or theoretical generalisations. Some case studies such as in this research study need not make any claims about the generalizability of their findings but are important for two reasons: firstly, they aim to present ideas about the phenomena. Secondly, where a single or few cases capture the phenomena under study well enough to reflect the general, typical and therefore logical occurrence of that phenomenon in the population then, they facilitate the transfer of findings from one setting to another on the basis of 'fit'. It is therefore important to note that the focus of this research is only on a few individuals and therefore insufficient to make any claims of generalizability. However, the inability to produce generalizable data does not imply that the data is invalid.
2. **Causal or narrative analysis** – case study research is assumed to identify causal processes in a way that is not feasible in survey research. Causal processes are important for theoretical basis of this study which adopts a critical realist perspective; which argues that case study research is one of the suitable methods that can best investigate causal processes (its key assumption) in the real world.

3. **Authenticity and authority** – case study research is advocated on the basis that it can capture the unique character of a person, a situation and even a group with the aim to represent the case authentically 'in its own terms' (Bloor and Wood, 2006). For instance, in this study, the aim is to capture unique and 'authentic' cases of housing experiences of PPLWHA through the use of their personal accounts. In addition, case study research can be used to amplify the unique voices of those whose experiences and perspectives are relatively unknown, neglected and at times suppressed; and in this study, PPLWHA.

Based on the key issues raised above, a case study was used as it offered the possibility of understanding the nature of a particular activity, in terms of techniques, procedures and system.

This study was proposed to be a general case study of Gaborone city with specific cases constructed from a sample of PPLWHA. However, despite the fact that the sample population was drawn from the city, some of the study cases were drawn from places outside the study area where housing is relatively affordable and easily available to the poor and low income people.

4.4.1 Choice of the Case Study Area

For an in-depth analysis of the housing problems and constraints faced and experienced by PPLWHA, Gaborone was selected for study for several key reasons listed below.

Firstly, Gaborone is the capital city, the largest and most populous city in Botswana. It is the only central place where the majority of the study subjects are available and accessible to the researcher: support groups for PLWHA, lands and housing policy makers and housing service providers.

Secondly, unlike in rural areas, people in Gaborone live a relatively urbanised life and are expected to be relatively open to share their HIV/AIDS challenges as needed to inform the study.

Thirdly, Gaborone as a city has several urban problems; housing in particular has received little investigation. This study is designed to investigate various issues related to housing for PPLWHA and hence contributes to knowledge in this field.

Fourthly, Gaborone is the only city in Botswana in which reasonable documentary data that could inform the study is available.

Within Gaborone, the choice of case study areas was influenced by the central aim of the research which is to analyse housing problems faced by PPLWHA. Therefore there was a need to obtain relevant and informative data from PPLWHA as consumers of housing services. Cases of PPLWHA to study were therefore derived from the support groups for people living with HIV/AIDS.

The choice of study cases was directed by two factors: firstly, neighbourhoods for poor and low income people and secondly, the existence of support groups for people living with HIV/AIDS within the chosen neighbourhood. Using these two factors as criteria for choice of cases yielded a limited number of neighbourhoods within Gaborone. Only three support groups were found within Gaborone and this prompted the researcher to include support groups which were based and operated from Gaborone but offering services to people living with HIV/AIDS in the areas within the periphery of the city (where the informal housing market is rife and housing relatively affordable for low income people).

4.4.2 Selection of Cases to Inform the Study

The selection of the cases to inform any study is important since the results and observations will often depend on the cases used. As already indicated unlike in quantitative research, cases need not be a fair representation of the population nor should they be representative of characteristics observed in the general population (Yin, 1994). Furthermore, critical realism promotes the use of intensive case study method rather than extensive searches for statistical correlations amongst multiple cases for searching for generative causes amongst structured, complex and open phenomena. Nonetheless, researchers must collect data from enough points so as to make meaningful conclusions about the areas of interest. For this study, seven support groups for people living with HIV/AIDS were identified although data was finally derived from only five support groups. Prior to the data collection process the researcher had to negotiate access to the various areas where data will be collected as discussed in the next section.

4.5 Negotiating Access to Research Sites

The decision to use a particular research site is tied closely to obtaining access to appropriate population of potential research subjects. It is important for researchers to ensure that the people selected into the research population should be appropriate and not merely an easily accessible research population.

Although data aimed to answer the research questions for this study is not exclusively on poor people living with HIV/AIDS, a larger degree of attention on issues related to ethics and access were focused on PPLWHA rather than other participants in the study due to the debates and issues related to HIV/AIDS. Studying people living with HIV/AIDS raised many questions with regard to access from the beginning, and therefore the issue of ethics and access were emphasised throughout the data collection process.

The difficulties and pitfalls of access negotiation have been well noted, in particular when sensitive subjects are under exploration. The difficulties are intensified when access to a population demands negotiating with powerful gatekeepers before proceeding to the study participants. Similarly to other studies[35] on HIV/AIDS, the process of negotiating access to this study was faced with challenges and pitfalls which will be discussed in detail in the next sections of this chapter.

Access to the potential participants was sought at different levels: governmental level to give permission to conduct research in the country; organisational level to seek permission to access the organisation and resources within the organisation, and finally the individual level to seek access to carry out interviews with individual people. These are discussed below in turn.

4.5.1 Permission to Conduct Research in Botswana

Securing an official research permit which allows researchers to carry out research in Botswana is a basic requirement. This requirement is aligned with the national aim to keep a record and have an archive of research activities that have been carried out in the country. Conducting research which involves human subjects or participants is governed

[35] See Kiai, Mwangi and Bosire, 2002 for more details on access problems related to studying people with HIV/AIDS.

by the Anthropological Research and Cinematographic ACT 1979 (ARCA 1979). This is administered through the Office of the President of the Republic of Botswana. Researchers are required by law to formally apply for permission to undertake research to the Permanent Secretary to the President, who can either grant permission to the researcher, normally with certain conditions attached to the permit. Permission can be refused if it is felt that the research will be detrimental to the subject. In view of this, the research permit[36] was secured a year (July 2007) prior to the data collection period through the Permanent Secretary of the Ministry of Lands and Housing. Securing the research permit does not however give access to the various populations of potential subjects; there was a need to arrange access with the potential subjects independently.

The study population was subdivided into three broad categories namely: housing consumers, housing service providers and housing policy makers. Access to these various categories was therefore gained independently. Access to each group was a process which had its challenges, difficulties and pitfalls which are considered in turn below.

4.5.2 Access to Governmental Housing Policy Makers and Housing Service Providers

Negotiating access commenced by sending an introductory letter to the purposively[37] selected potential study subjects namely: Lands and Housing governmental departments responsible for policy making and housing service providers[38]. These departments were purposively selected into the sample for interviewing. These interviews were necessary and helpful to the study since the government departments in question are key units involved and responsible at different levels for designing and overseeing the implementation of the lands and housing policies in the country. To gain insights into the impact of HIV/AIDS on the housing programmes for low income people, one had to engage with the bureaucrats concerned. Bryman (2004) suggests that the researcher adopt purposive sampling strategy when the study aims to select people who are relevant to the research questions. Purposive

[36] See Appendix A, B and C for the research permit application details.

[37] The study used purposive sampling strategy to choose a sample of government departments relevant to this study including; Department of Lands, Department of Housing, Department of Social Services and Gaborone City Council-Department of Housing.

[38] See Table 4.2 (Pg 134) for the extensive list of the departments that participated in this study

choice of the governmental departments dealing with lands and housing policy formulation and implementation for this study was based entirely on availability because the people selected into the sample were the only ones available in the entire country.

In all these departments and organisations, access had to be secured through top management personnel. The aim at this initial point was to introduce the study as well as request access for data collection. Bloor and Wood (2006) noted that researchers initially approach their settings through a 'gate keeper' who controls access to the setting. The gatekeeper may not always be a member of the study population but has the responsibility for allowing access and often wants to protect the interests of the study population (Bloor and Wood 2006). On the same contention, Bryman (2004) has observed that senior executives act as 'gate keepers' to organisations although in some instances they end up assigning the responsibility to junior staff members as was evident in this study.

Access to government departments was negotiated through the office of the Director for the individual departments concerned. Although securing access to government departments generally involved some degree of bureaucracy, in practice access negotiation was relatively open. Bloor and Wood (2006) rightly observed that gaining access to organisations dealing with political agendas such as policy making can be difficult as such groups dealing with policy matters have the ability to resist the scrutiny of social researchers. Four Departments - Lands, Housing, Social Services and Gaborone City Council - were contacted[39] with an invitation to participate in the study.

The response to the invitation letter to the government departments was varied. The researcher expected a smooth passage into the government departments based on the personal assumption that the study seeks information that is arguably 'not confidential' and therefore access to information will be open. However, some departments were evidently relatively concealed from the researcher's access. As Homan (1991) observed, it is widely recognised that powerful people can use the principle of confidentiality in an attempt to protect themselves from public scrutiny. In response to these blockages into some of the governmental departments, the researcher had to make several follow-ups through physical

[39] A letter was written to different departments requesting permission for access to conduct research. A similar letter was edited and used for access requisition from all other organisations involved in this study. See Appendix D for the sample letter.

visits to the Directors' offices in an attempt to accelerate the access process. The visits aided the access negotiation process to some extent as two out of the four departments agreed to participate in the study within two weeks of invitation while the other two responded positively after a period of over one month despite the repeated visits to the Directors' offices by the researcher.

Considering that the researcher had limited study time, the negotiation to access the government departments was a big challenge. Although securing access to the departments' Directors was a positive step, only one Director (Lands) agreed to be interviewed while two (social services and housing) assigned the responsibility to junior staff members, all forwarding reasons of 'busy schedules'.

It has to be noted that during the time of data collection for this study, the department responsible for housing for low income people within the Gaborone City Council was undergoing restructuring. Therefore the former Principal Housing Officer of the former department responsible for low income housing was transferred to a different District. This posed a huge challenge to the researcher as the new person in charge of housing low income people was evidently not best placed to be interviewed as he had been in the office for less than a month and therefore relatively new to respond to the interview questions informatively to the benefit of the study. The researcher therefore made an alternative decision to recruit a substitute person who will give an account of housing programmes for low income people with a degree of experience and thorough knowledge of the department. The former Director was the best possible alternative to participate in the study on behalf of Gaborone City Council so the researcher recruited him into the sample without much difficulty.

In non-governmental organisations (NGOs) access was relatively easy and this could be related to their culture and attitudes: NGOs deal with international financial and resource donors more regularly than the governmental organisations and therefore they can arguably be open to sharing information and relatively readily prepared for the public to scrutinise their organisations' motives and interests.

Access to the private sector was the most problematic. A total of six banks including four commercial banks, the one and only building society, and the National Development Bank

were approached to participate in the study. The building society and the National Development Bank were fairly open hence approving to participate in the study. On the contrary, all the four commercial banks that were potential subjects of research declined access to their organisations entirely. Two commercial banks declined outright while the other two never responded despite further requests to partake in the study being made by the researcher. In this case, the researcher attempted to resort to covert research to gain access to the data by posing as a client in two of the commercial banks but was obliged by the ethical considerations to discard the idea. Covert access to research is defined as undertaking research without the consent of research subjects by the researcher posing as an ordinary member of the group (see Bloor and Wood, 2006 and Silverman, 2005). Engaging in covert research would have raised two main difficulties for the researcher:

Firstly, it would have limited both the quality and quantity of data collected as the researcher would have been obliged to ask unsuspicious questions that could be asked by any customer and hence diverting from the questions designed to answer the research questions.

Secondly, and crucially, the research had to observe the ethical issues surrounding the use of covert research. Although the statement of the British Sociological Association states that the use of covert methods may be justified in certain circumstances, instancing the denial of open research access by powerful gatekeepers, the researcher decided to discard the idea for the reasons including: betrayal of trust that could lead to legal issues should the researched discover that they were studied even after clearly denying access to the researcher; and the possible adverse effect on research access for future researchers (for further discussion of ethical considerations done in this study, see Section 4.6 of this chapter).

Gaining access to the various organisations and departments only meant that the researcher is authorised to conduct the study within the departments and organisations and not necessarily provided passage to the specific people to interview in the respective offices. It was therefore necessary for the researcher to negotiate access to the delegated individuals and representatives of the departments and organisation to partake in the interview process. The researcher therefore had to schedule interview appointments convenient for the potential participants; which proved to be another long process as the researcher had to

struggle to fit into the 'already busy' schedules of the potential interviewees. Ultimately a total of twelve people were purposively recruited into the sample and interviewed: five people within the category of policy makers and seven for housing and support service providers[40].

4.5.3 Access to Poor People Living with HIV/AIDS

Access to the poor people living with HIV/AIDS was anticipated to be a potential obstacle from the initial stage of the study predominantly for ethical reasons, as HIV/AIDS is clearly a sensitive subject. However, access to the people affected with HIV/AIDS was greatly facilitated by initial access obtained through the national HIV/AIDS Support Group Coordinator who acted as a 'key informant'. It is of great importance to note that the process of recruiting people living with HIV/AIDS into the sample was potentially impossible through the independent efforts of the researcher. The process was not only a daunting task but also a potentially illegal act in a country in which 'labelling' a person 'HIV positive' without their informed consent and/or evidence from a medical report may be considered as stigmatization, inhuman and degrading treatment (Ndadi, 2008). Based on that consideration, there was a vital need to have a point of access that is legal and ethically acceptable to access PPLWHA to include in the sample. Botswana Network of People Living with HIV/AIDS (BONEPWA) was therefore approached for support with the process of access to the support groups.

It is significant to note at this point that the process of recruiting PPLWHA was in the form of a snowball sampling strategy. For initial contact, the National HIV/AIDS support group coordinator acted as the key informant.

'Snowball sampling' is a non-probability sampling strategy which is respondent-driven and good to locate subjects with certain attributes or characteristics necessary for inclusion in the study: particularly when the study involves sensitive topics or populations which are difficult to reach. Snowball sampling was useful in this case because the population of people living with HIV/AIDS can be regarded as 'difficult to reach' due to the nature of the disease: there are issues of confidentiality, sensitivity and privacy. However, the people

---

[40] See Table 4.2 (pg134) for the details of the people interviewed.

with similar circumstances know each other relatively well and are therefore beneficial in directing the researcher to the relevant people who are suitable to make potential research population without much difficulty.

The basic strategy of snowballing involves identifying several people with relevant characteristics at different levels, who then refer the researcher to the potential study subjects until the desired sample size is obtained. The different levels of access into the study population for this research is summarised in Figure 4.2 and thereafter discussed in-depth below in turn to explain how access was sought at each level.

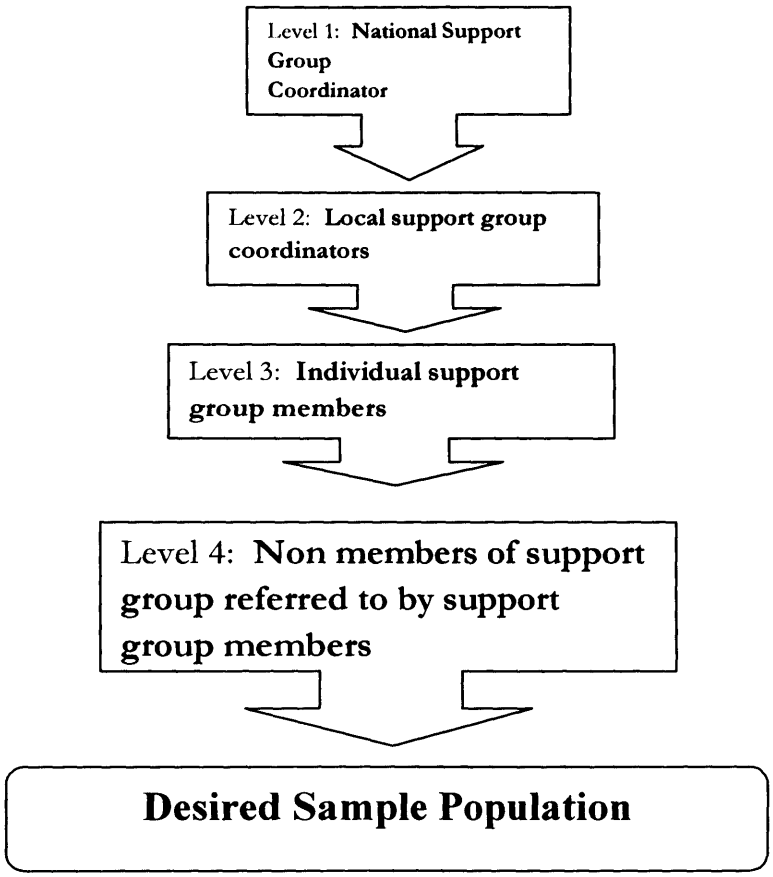

Figure 4.2: The Snowball process used to populate the sample of PPLWHA in this study

The initial access point to the support groups, as already indicated, was sought through a key informant; the national HIV/AIDS Support Group Coordinator , who acted as an entry point and therefore can be referred to as a key informant.

a. Access through the National HIV/AIDS support group coordinator

The assistance of the national HIV/AIDS support group coordinator was critical in the provision of a legal and ethical platform to access people who are affected and infected by HIV/AIDS through the support groups[41] for people living with HIV/AIDS. The national support group coordinator had a record of registered HIV/AIDS support groups, which aided in the establishment of the sampling frame of the support groups.

A number of problems and constraints were encountered during the access negotiation process with the office of the national HIV/AIDS Support Groups Coordinator at BONEPWA. In general, the process of negotiation of access to the research data sources was a challenge as it was painfully slow at the beginning. Access to the support group for people living with HIV/AIDS was affected by the national support groups' coordinator's absence from the office for almost two weeks on an official international trip. This delayed the initiation of the sample building process because the national support group coordinator was the key informant and therefore the keyto the potential sample for people living with HIV/AIDS.

The researcher had the potential to accelerate the process of contacting the support groups independently of the national coordinator. However, as much as it was potentially possible and would undoubtedly reduce the time used in the access negotiation process, it equally proved to be a disadvantage for two particular reasons. On the one hand, the decision was based on ethical responsibility that directed the researcher to follow the correct access procedures and channels in order to contact the study subjects; on the other hand, it was hypothesised to be much easier and ethical to access and build trust with the support groups on referral by the national coordinator acquainted with the support group

[41] A support group for people living with HIV in this study refers to a forum where people affected and infected with HIV/AIDS are liberated to discuss and share on issues related to their HIV status in a relatively open but supportive atmosphere.

coordinators than when acting independently. Ultimately the national support groups linked the researcher with the local individual support group coordinators.

b. Access through the individual support group coordinators

A list of seven support groups and their contact details was supplied by the National support group coordinator. Upon securing the list of contacts of the support groups that operated in and around Gaborone, the case study area, the second stage of access to the support groups resumed. A letter introducing the study as well as recruiting the research participants was hand delivered by the researcher to all the seven support groups. The process of hand delivering the mail was intended to assist in speeding the process. Considering the limited amount of time at the researcher's disposal, on the one hand the process proved to be efficient and effective to some extent. On the other hand, the results were contrary, the hand delivering process was time consuming and economically challenging: some support groups had since relocated and therefore the researcher had to trace their new locations, which added to the travelling costs.

In general, securing access to the different support groups was reasonably easy as the majority of the support groups were observed to either be faith-based or to some degree relied on international donors for financial assistance for their initiatives. As Bloor and Wood (2006) have observed, institutions such as churches and charitable organisations usually have a greater degree of openness. The key contacts for access to the support groups were their coordinators. From a total of seven support groups invited to participate in the study, three coordinators declined access to the support group members. One of the support groups which declined was relatively new and therefore the coordinator was reluctant to involve researchers at that early stage of inception of the group: however the coordinator participated independently in the study. Four other group coordinators showed the willingness to engage with the research and act as key informants, resulting in the recruitment of further PPLWHA within and outside their support groups. However, all the support group coordinators did complain about research fatigue, complaining that there are many research studies done with them without any results beneficial to the PPLWHA. However, it was of crucial importance for the researcher to negotiate informal access with the individual PPLWHA referred to by the support group coordinator. This was a

necessary step to take as participation in the study needed to be an act done willingly and an independent decision made by the individual PPLWHA.

c. Access to the individual poor people living with HIV/AIDS

When access to the support groups was finally secured, getting individual poor people living with HIV/AIDS to participate in the study started but at a slower pace than anticipated. The coordinators had to meet with individual potential participants prior to introducing the researcher to them. The process was slow: three particular problems were apparent to the slow start of the process and they are discussed below in turn.

Firstly, there was some degree of unwillingness to participate due to research fatigue: the potential participants were reluctant to participate, complaining that they host several researchers in their support groups but never evidence the implementations of recommendations derived from the research findings. As Silverman (2005) noted, the impression the researcher gives to the researched may be very important in granting access. In the attempt to persuade the PPLWA to partake in the study, the researcher had to convene a meeting with the support group members to clarify the nature of the research, locating it as academic work although its findings and recommendations may be beneficial in future policies and programmes aimed towards helping the poor people affected and infected with HIV/AIDS.

The second challenge was faced when recruiting PPLWHA to voluntarily participate in the research. This attempt failed in all but one support group despite being persuaded by the support group coordinators and given clarification on the intentions of the study. Participants needed to be offered reciprocity in a form of pecuniary (cash) incentive to participate in the study. This was required by most potential participants to compensate for their time and in some instances reimburse travel expenses since most interviews were conducted at the support groups' centres. Although the cash incentive offered was little in value, it improved the participation rate tremendously. Prior to introducing the incentive, a total of eleven PPLWHA including five coordinators showed willingness to participate in the study. However, subsequent to the incentive offer, a total of twenty six PPLWHA participated in the study. It has to be noted that for consistency, fairness and just treatment the researcher provided the incentive to all the PPLWHA who participated in the study.

In their study on 'Incentives and Ethics in Human research', Grant and Sugarman (2004) noted that the use of incentives to recruit and retain research subjects is entirely innocuous if used appropriately. They, however, argued that there is a need for researchers to use incentives responsibly for the benefit of both the researcher and the researched, ensuring that there is minimal harm and risk to any one of them. Based on this principle, offering research participants incentives for this study was done without any ethical doubts because all other ethical criteria were observed and will be discussed in the proceeding section on ethical considerations. The researcher had the participants' voluntary consent on involvement in the study which was further emphasised by the researcher even after offering an incentive. The researcher clearly indicated to the research participants that the incentive did not bind them to participate in the study and they could withdraw their participation from the study at any time.

The cash incentive was self-sponsored by the researcher. Therefore, as much as it benefited the study, it equally proved to be a costly exercise on the researcher's finances.

The other evident challenge in this study was recruiting male participants into the sample of poor people living with HIV/AIDS. The attempt was unsuccessful for several reasons. In their study entitled 'Women's rights and HIV/AIDS in Botswana' Physicians for Human Rights (2007) reported that more women disclose their HIV status than men and this contributes to gender inequality in participation in support groups for people living with HIV/AIDS. Furthermore, one local newspaper reported that men's negative attitudes to participation in HIV related initiatives undermine the efforts to control the epidemic. This was indicated by the unsuccessful HIV/AIDS sensitisation workshop for males organised in one of the cities in Botswana as reported below.

> ".....I vividly remember a failed HIV/AIDS sensitisation workshop for males at Francistown which was hosted by True-Men, a men's sector HIV/AIDS group. The failure of that workshop is a telling indicator that males are contemptuously undermining the transcendental value of all strategies and methodologies aimed at combating the HIV/AIDS....I judge it pivotal to lobby for swift obliteration of this masculine crass ignorance. How do we interpret the fact that out of 200 males invited at that workshop, a perceptibly negligible 60 males managed to attend the same?" (The Botswana Gazette, 21 January 2010)

The same newspaper report commented on the general patriarchal traditions and customs that shape men's attitudes in Botswana asserting that people believe that 'Males who take HIV tests are martyr to showcasing contemptible cowardice'

Based on these observations, the researcher could hypothesise that men in Botswana are generally less willing than women to engage in HIV/AIDS initiatives and research as was evident in this study. The inclusion of male participants could have been of great importance for this research to balance the gender as out of the twenty six people living with HIV/AIDS interviewed, there was only one male participant. This had an impact on the composition of the sample, although unintentional. The coordinators indicated that they had very few male members in the support groups and those belonging to them are relatively inactive in the daily activities of the support groups. A potential area that could have assisted with access to men living with HIV/AIDS could have been the availability of 'male only' support groups, but it transpired that none existed in the entire country at the time of the study.

Ultimately, a sample of twenty six people living with HIV/AIDS was achieved within which three did not belong to any support group. The support groups' coordinators assisted with the recruitment of these people through the extensiveness of their network, experience and personal relationships with people living with HIV/AIDS in the community.

4.5.4 Access to the People Indirectly Affected by HIV/AIDS

To have insights from poor people who are indirectly affected by HIV/AIDS, a convenience sample of six people was drawn into the study population. As Bryman (2004) points out, a convenience sample is the one that is simply available to the researcher by virtue of its accessibility. A total of six low income people residing either in the SHHA area in Gaborone or in the outskirts of Gaborone was purposively selected into the sample without any representation motives. This group was primarily included in the sample to provide an insight from a handful of people who are not infected with HIV/AIDS but are exposed to relatively similar characteristics with the main study subjects being poor PLWHA. Although this group (poor people indirectly affected by HIV/AIDS) was not empirically strong, it is significant to the study for informed insight on the impact of HIV/AIDS from those people who are neither HIV positive nor AIDS suffers but share

similar political[42], socio-economic conditions and cultural background and experiences with the PPLWHA.

4.6 Ethical Considerations

This study is primarily focused on PPLWHA and therefore the researcher has to acknowledge it was pivotal to consider methods by which the research will be conducted in an ethically justifiable manner. The section below discusses the ethical issues considered in the study with particular emphasis on issues that were considered for the data collection process.

Studying people living with HIV/AIDS is naturally sensitive and to some extent controversial due to the stigma and discrimination attached to the disease. Other researchers have shown the difficulty of doing research studies related to HIV/AIDS elsewhere. Kiai, et al (2002) indicated that it is difficult to identify people infected and affected by HIV/AIDS without ethical hindrance. Therefore, even for this research, the researcher anticipated that issues and problems that required ethical justification will be inevitable and hence the need for ethical pre-arrangements.

Prior to the field work, ethical clearance was obtained through the Cardiff University School of Planning Ethics Committee to demonstrate that the school has considered the study and approved that it observes and meets the required ethical standards of research. Throughout the data collection process, the researcher was guided by the contention that ethical decisions are not defined in terms of what is advantageous to the researcher or the study but they are concerned with what is right or just in the interest of not only the study but also others who are the participants in the research.

On consideration that although the data was collected from research participants based in Botswana, the research is based in Cardiff University consequently the researcher was 'rightfully' guided by the guidelines stated in the 'statement of ethical practice (2004)' by the British Sociological Association (BSA). Based on clauses 10 to 30 and 34 to 41 entitled

[42] Botswana has only one national housing policy namely Government Paper No. 2 of 2000 on National Policy on Housing in Botswana, whose aims are targeted at housing needs of all people in the country regardless of their special circumstances.

'the responsibility towards research participants' and 'anonymity, privacy and confidentiality' respectively, this research study did attempt to protect the rights of the participants, ensure the absence of harm and minimise the risk (if any) involved to both the research participants and the researcher as reported below in turn.

The researcher designed and administered a 'consent form[43]' which was signed by all participants for informed consent prior to the interview. This process guaranteed to the research participants that participation in the interview was a choice, free from any element of deceit, duress or similar unfair inducement or manipulation (May 2001; Bloor and Wood 2006). Following the guidelines set out in the BSA on the importance of informed consent, prior to each and every interview, the researcher explained to each participant what the research is about, the role of research participants in research, why the research is being undertaken and what the data will be used for. Furthermore, research participants were given the latitude to retract consent at any stage of the interview according to their desire.

Anonymity and confidentiality are very important factors that need to be observed by researchers. In this research, although all the participants agreed to be voice recorded, the use of a voice recording device to record the data presented the researcher with issues and concerns of anonymity. The respondent's exact words and voice were recorded and consequently posed a danger of disclosure of the participants' identity. The researcher hence ensured that the participants were aware of the intention to record their voices before giving their consent and also assured them prior to the interview that there will be no other person who will have access to the recorded interview. Latitude to request the researcher to switch off the voice recorder at any time during the discussion was given to the interviewees, and consequently some interview participants requested to discuss some issues off the record, and with the tape off, during the interview. Participants were reassured at the end of the interview that the data will be anonymized upon transcription and that a pseudonym would be used to replace their actual names.

Dealing with people living with HIV/AIDS always poses a potential for both emotional and psychological harm; due to the nature of the disease that is highly associated with discrimination and stigmatisation. Therefore, the fundamental concern was to minimise the

[43] See Appendix E for a sample interview consent form

potential harm to both the researcher and the research participants that could surface during the study without disputing that it is not entirely possible to identify in all circumstances whether harm is likely (Bryman, 2004). For some participants in this study, relating their life stories was an emotional experience which could arguably be found to be a potential emotional and/or psychological harm to the concerned participant. Being aware of the potential for harm in terms of anxiety, stress, self esteem and invasion of privacy as well as anticipation of emotional response, the researcher attempted to minimise as much as possible the potential harm through indicating to the participant the liberty to be selective on what they can volunteer to respond to. This offered the participants the freedom to answer questions and issues that they find appropriate and feel comfortable to discuss. However, four research participants became upset during the introductory session at the opening of the interview; when they introduced themselves, their HIV status and their housing arrangements. They however insisted on continuing with the interview and appreciated it at the end. One participant who was emotional at the beginning of the interview referred to the interview as a 'good opportunity' to speak to someone they don't know about their problems to get them off their chest. To the researcher, being emotional was thought to have potentially caused a degree of psychological harm to the participant. Nevertheless, these incidences of emotional response from the participants, indicated that as much as the researchers strive to minimise harm to the participants through putting measures and precautions in terms of respect for them as people, their dignity, their values and beliefs and preferences, there is a practical difficulty of inability to know the internal psychological state of everyone who volunteered to take part in the research (Grant and Sugarman, 2004).

4.7 Sample Size

Given the limited time and financial resources available for the entire data collection coupled with its theoretical basis, the study could not aim for a sample which would be representative of the entire population of PPLWA in strict statistical terms but for a sample large enough to draw insights and conclusions from. In practice, for the policy makers, housing service providers and other housing stakeholders the size of the sample was influenced largely by the number and size of the organisations dealing with issues under study. For the sample of PPLWHA, the sample size was influenced by the financial

resources and time available for the data collection. In the end, the sample was in turn divided as follows:

Table: 4.2: The Summary of Interview Participants			
SAMPLE CATEGORY	**Number of participants**	**Participants position**	**Number of participants**
Lands and housing policy makers:	5	Director of Lands Head Destitute Housing Research and Development Officer (DoH) Principal Housing Officers (former SHHA and former Department of Housing	1 1 1 2
Housing and support service providers:	7	Senior Estates Officer (Botswana Housing Corporation) Programme Manager (Habitat For Humanity Botswana) Bank Managers (Botswana Building Society and National Development Bank) Insurance company Manager (AON) HIV/AIDS Support services coordinator (BONEPWA[44] and BONELA[45]	1 1 2 1 2
Poor and low income people living with HIV/AIDS:	26	Support group coordinators (HIV+) Support group members (HIV+) Public members (HIV+)	5 18 3
Low income people indirectly affected by HIV/AIDS	6	HIV negative people	6
TOTAL SAMPLE	**44**		**44**

[44] BONEPWA – Botswana Network of People Living with HIV/AIDS

[45] BONELA – Botswana Network on Ethics Law and HIV/AIDS

The researcher acknowledges that the greatest disadvantage with non-probability samples is the lack of representativeness of the population and the consequent difficulty in drawing general conclusions. As observed by Yin (1984), unlike quantitative research, cases in the sample do not need to be a fair representation of the population, nor should they be representative of characteristics observed in the general population unless when the study aims to seek generalisations. However, as it was not the central aim of this study to produce representative results, but rather to enlighten the research problem at hand and to that extent, the chosen sample sizes, approaches and design were considered adequate.

4.8 Data Collection Methods and Limitations

The basic data collection strategy for this study involved the use of triangulation of both primary and secondary data sources. Primary data was derived from semi-structured interviews and field observations. Secondary data search was from published and unpublished documents. The following section will discuss the triangulated methods used for this research.

4.8.1 Triangulation of Methods of Data

Triangulation refers to a 'combination of methodology in the study of a single phenomenon' (Denzin, 1989, pp. 234). In this citation Denzin delineates triangulation as the use of multiple data collection methods. The use of multiple methods is intended to reduce error and bias which can be imposed on the study as the result of an inherent problem resulting from study by the adoption of a single method (Hussey and Hussey, 1997). By adopting different methods for sourcing data the research study will be presented with the opportunity for the cross validation of data which is often difficult to accomplish in qualitative research by using a single data collection method (Janesick, 1994: Bonoma, 1985). Multiple methods also offer the study the opportunity to explore the inter-relationships and inter-connections of the research findings from individual methods used.

However Bloor and Wood (2006) contend that as much as triangulation is capable in terms of validation of data, there are equally some problems associated with it. Firstly, the researcher using the triangulation of methods has to acknowledge that for any particular research, there will usually be one best method by which it may be addressed. Evidently, in

this research, the interview method was the most suitable way to collect data because as Bloor and Wood say, 'matters of belief may be best addressed by use of interviews' (p.105). The rest of the methods used were field observation and document analysis which were particularly used for supplementary and corroboration purposes.

Secondly, Bloor and Wood (2006) argue that in theory, the chances are that the findings from the triangulated methods will corroborate almost perfectly while in practice comparison of results obtained by different methods is rarely unambiguous because one of the methods used may miss out some topic areas covered by the other or even fail to record variations and exceptions noted in the other method and hence corroboration is impossible.

These criticisms of triangulation-as-validation only notes the weaknesses of the process but supports the view that data derived from different methods may serve to deepen and extend the data analysis.

Thirdly, the weakness of the multi-method research strategy was that it entailed greater use of resources in terms of time, effort and money.

The different methods that were adopted in this study included structured interviews which covered four different groups of people: housing policy makers, PPLWHA, housing and financial service providers and people indirectly affected by HIV/AIDS. Field observations of the housing structures used by PPLWHA and the review of published and unpublished archival records and official policy documents were used to supplement and corroborate the data collected through the semi-structured interviews. Each of the methods will be discussed in detail in the subsequent sections.

The use of triangulation was not limited to methods, but was extended to include the triangulation of data. Triangulation of data refers to the collection of data from different sources or at different times and is used for providing descriptions, classification, theory development and theory testing (Bonoma 1985). In this study, triangulation of data was used to provide a wide range of informants on land and housing delivery. The sources of such data included that from different role players in housing delivery to explore and assess the role they play in the research problem: Firstly, consumers (PPLWHA and those indirectly affected by HIV/AIDS) provided a detailed account of the housing problems and difficulties they face in their daily lives as well as the coping strategies that they adopt to

deal with the problems and difficulties at personal level. The housing policy makers provided data that identifies the national responses to the difficulties of HIV/AIDS in acquiring land and housing for the poor people living with HIV/AIDS; while the housing policy implementers (land and housing service delivery personnel) presented the institutional responses available and intended to counteract the difficulties of poor people living with HIV/AIDS.

4.8.2 The Pilot Study

A pilot study was carried out as a part of the initial data collection phase of this study. For this phase of the study, semi-structured questions were developed for guiding the interview. The purpose of the pilot study was twofold. Firstly, it provided an insight into the problems and constraints experienced by poor people living with HIV/AIDS in housing at household level. Secondly, it provided an avenue for the refinement of the research instrument and the alterations of research plans and interview schedules before the main study was conducted, something that assisted with the reliability of the data collection instrument.

Three people whose HIV status was not disclosed were randomly selected from the low income neighbourhood for interview using the interview guide designed for the people living with HIV/AIDS. Although the people involved in the pilot were supposedly not directly affected by HIV/AIDS, they were poor people living in houses commonly used by the poor and therefore their personal accounts provided a 'feel' of the problems faced by poor people in housing. The response from the pilot study guided and gave the researcher the opportunity to refine, refocus and explore the interview questions. After the pilot study, the data collection process started in earnest as discussed in the preceding sections.

4.8.3 Semi-Structured Interviews

A substantial part of the research was collected through interview data. Interviews are used as a resource for understanding how individuals make sense of their social world and act within it, as noted by the quotation below:

> "Interview data report not on an external reality displayed in the respondent's utterances but on the internal reality constructed as both parties contrive to produce the appearances of a recognisable interview." (May, 2001:143)

Furthermore, as Yin (1994) puts it, an interview provides insights about human concerns and human issues reported through the eyes of specific respondents. Based on the above understanding, the interview was the most suitable method for the study whose primary aim is to explore the problems and constraints people living with HIV/AIDS face in their housing on their day to day life experiences through personal accounts and opinions. However, the researcher took into consideration reservations surrounding personal accounts: that while they may be a genuine reflection of people's experiences, personal accounts can also be inaccurate and there might be circumstances or events which surround these experiences which the respondents may not be aware of. Therefore, the researcher had this contention in mind throughout the interviews. Furthermore, participants may say what they think the researcher wants to hear therefore revealing certain information so as to present themselves in a particular way, suppress certain feelings so as not to upset themselves, and even modify the story to protect themselves from certain emotionally painful memories. The personal account may just reflect the individual's feelings at the present time. In this case, it is important for the researcher to recognise that interviews may produce partial information. However, as Brunner(1993) quoted by McKechnie (2007) noted, it is crucial to acknowledge that it is not the task of the researcher to decide which statements are true and which are false but to accept that any narrative given by the participant will inevitably be incomplete.

The principal research strategy involved the use of semi-structured interviews[46] with all the four groups covered in this study: housing policy makers, housing service providers and housing consumers including poor and low income people living with HIV/AIDS and those indirectly affected by HIV/AIDS.

Semi-structured interviews were adopted as the principal tool and main interview format for its benefits. Berg (2009) describes semi-structured interviews as involving the implementation of a number of predetermined questions and special topics asked to the participant in a systematic and consistent order but allowing the freedom to digress: seeking both the clarification and elaboration on issues under discussion. The semi-structured interview was beneficial to both the interviewer and the respondent: it afforded the researcher the provision of flexibility in conversation as it provided the platform to

[46] See Appendix F, G and H for samples of the interview guides used in this study.

intensify the inquiry in situations where more information can be offered while providing the respondent the latitude to provide as much information as they wish to divulge, on their own terms.

For housing policy makers and housing service providers, a number of office bearers and other key individuals were principal respondents for the interviews. These were relevant authorities who were expected by the researcher to possess specialised knowledge of various aspects of housing policy and are engaged in its formulation and implementation in the various organisations, governmental departments and sections dealing with housing with particular emphasis on poor and low income housing.

A semi-structured interview strategy was also used with people living with HIV/AIDS that were selected for the study.

Since the study primarily aimed to acquire personal life experiences it was anticipated that there would be a need for privacy and therefore for the confidentiality of data provided this could only be afforded by the use of a one -to -one interview strategy. The semi-structured interview was therefore found to be appropriate for this study mainly because HIV/AIDS is a confidential, personal and sensitive topic to discuss.

a. The Interview Process

The researcher herself conducted all the interviews with the various groups of people involved in study. All interviews were captured into a portable digital voice recorder (Olympus WS- 210S). As already stated, for ethical reasons all interview participants were asked whether they had any objections to using the voice recorder prior to the interview and they all agreed to it.

The interviews were conducted in both English (Botswana's official language) and Setswana (the local language). The interviews with the policy makers, housing service providers and HIV support service providers were mainly conducted in English based on the contention that the participants were professionals and therefore used English to some extent in everyday language. All the interviews with the people living with HIV/AIDS and the indirectly affected people were conducted primarily in Setswana but participants were at liberty to use English as and when they felt comfortable to do so. This was found

necessary as it consequently afforded the interviewee the opportunity to disclose as much information as they could in both languages.

b. The choice of interview setting

The setting in which the interviews were conducted is important to both the interviewer and the interviewee as it has a contributing effect of encouraging or restricting the discussion.

The interviews were conducted in various places for the different groups of people. All interviews for the lands and housing policy makers were conducted in their offices at their convenience.

In the case of people living with HIV/AIDS, the potential interviewees were given a flexible choice of venues for the interviews namely: the researcher's temporary office that was arranged by the University of Botswana (the researcher's academic sponsor), the interviewee's home, the office provided by the support group coordinator at their centres or any informal place chosen by the interview participant. This was done to offer the participant some flexibility and the choice of settings where they may feel comfortable and less intimidated hence are encouraged to divulge as much information as necessary to inform the study. The researcher anticipated that PPLWHA may find it convenient to conduct the interview in the comfort of their houses in their own spaces. However, on the contrary, most of the participants chose the office in the support group centre for the interview. Two reasons became apparent as to the influence of the choice of the setting PPLWHA made. Firstly, the support group centre was their usual meeting place and as such offered an informal, less intimidating and comfortable setting for the interview. Secondly, most PPLWHA lived in poor housing conditions and therefore found it intimidating as it would publicize their private place of residence. However, after the interview, three PPLWHA willingly offered the researcher the opportunity to make an observation of their places of residence in order to confirm the information they gave during the interview.

Despite the different interview settings, all interviews equally yielded good insights and provided the study with rich data. A summary of the different venues for the interviews with the people living with HIV/AIDS is outlined in Table 4.3.

Table 4.3: Interview venues				
Interview Venues	**PPLWHA**	**People indirectly affected by HIV/AIDS**	**Policy makers and service housing providers**	**TOTAL**
Participant's Home	4	0	1	5
Support Group or work office	23	2	11	36
Researcher's Office	0	4	0	4
TOTAL	**27**	**6**	**12**	**45**

Source: Author

c. The actual interview

Prior to all the interviews, the researcher took time to clarify to the participants issues of confidentiality, privacy and research ethics as well as to establish a rapport. Rapport is of paramount importance in interviews because it allows for the development of mutual trust that permits the free flow of information (May, 2001). Rapport building developed quicker than anticipated for the majority of the participants. In that respect, it assisted the transition of the interview process to instantly progress into the main interview questions without problems. However, the initial moments of the interview were consistently tense for most of the participants but, as the conversation developed, the tension reduced and consequently participants started giving rich and insightful information. Each interview was intended to be conducted within a period of 30 minute to 45 minutes. However, the interviews lasted between 25 minutes and 1hour 30 minutes. Although the interviews were conducted in a semi-structured basis, each interview had its unique levels of being structured depending on the story and experiences of individual participant. Some interviews were more or less structured than others.

Every interview was approached with a list of topics to be covered although some responses given in the interviews probed the researcher to make on the spot decisions about the content and sequence of the interview as it progressed. As Manson (2002) correctly observed, qualitative interviewing is hard, needs creativity, active thinking and

the researcher has to 'think on their feet' in order to make the best use of the interview process.

The interviews were thereafter transcribed and concurrently translated into English by the researcher verbatim from the tapes. The process of translating is discussed in turn below.

4.8.4 The Concept of Translating Interviews

Undertaking qualitative research with non-English language and translating to English can be a complex process. In this study, translation is defined as the transfer of meaning from a source language to a target language. In this context the translator acts as an interpreter and is responsible for conceptualising the meaning and using vocabulary and grammatical structure appropriate for the target language. The interpreter has to reconstruct the meaning of the statement in a new context (Esposito, 2001)

Esposito (2001) contends that translating of the data between different languages may to some extent influence the reliability and validity of the research findings therefore there is a need for consideration of that fact when translating data between languages. This was echoed by Twinn (1997) who noted that using different translators provides different interpretations of data hence impacting on the reliability of the data and implications on the outcome of the findings.

Based on that contention, the researcher decided to be the sole translator of all the interviews, with the assumption that it is important to use only one translator in order to maintain consistency and to maximise the reliability. In an exploratory study by Benner (1994) as quoted by Twinn (1997), it was suggested that translation, although complex, may put at risk the findings of a phenomenological study where the major purpose of the study is to capture the essence of the phenomenon from the perspective of the participant. More significantly, the result of that study demonstrated some important issues to consider when using translating in qualitative research; in particular, the complexity of managing data when the true equivalent of some words and phrases is deficient, as was evident in this study.

a. The translating process

In qualitative research, the first major task is to translate the researcher's questions and meanings into a form that is understandable to the interview participant.

Thereafter the researcher has to translate the participant's communication into a form that is understood by and meaningful to the researcher. In this study, the exercise of translation was found to be time consuming and labour intensive although it ultimately yielded rich data. The model in Figure 4.3 indicates the process of translating, interpreting and transcribing data that the researcher undertook for this study.

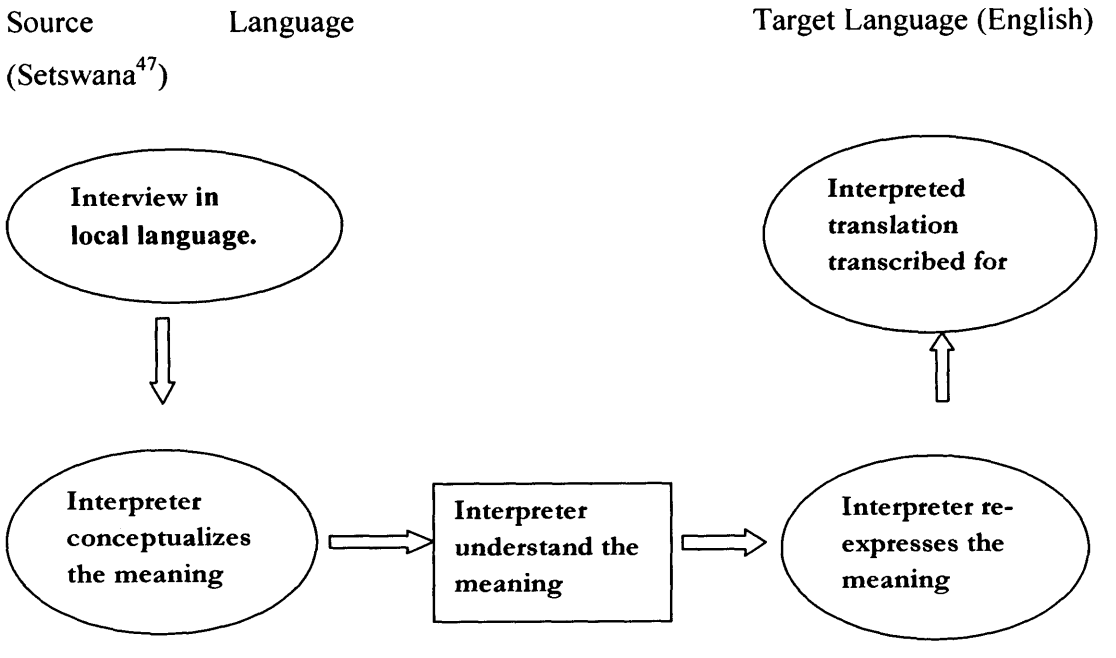

Figure 4.3: The translating process from the interview

(Adapted by author from Esposito, 2001: 571)

[47] Setswana is a local language that is spoken by all people in Botswana; however English is the official language for the country.

The translation process started from the data collection tool which was the interview guide designed in the target language (English) and then translated into the source language (Setswana) to be usable with the interview participants who are non-English speakers. Thereafter translation was done subsequent to the interview whereby the data was re-translated from the data source language (Setswana) to the target language (English); a concept also known as 'back translation'.

In the process of translation the researcher made interpretations of words, concepts and phrases to give them a meaning and ready for data analysis. Given the translation process involved, it is important to position the translator and/or interpreter linguistic strength. In this study, the researcher was responsible for both the translation and interpretation. The researcher found it necessary to personally engage in both the interpretation and translation for the following three main reasons.

Firstly, and most importantly, the researcher has a good background in both languages used in the interviews. On the one hand, English is an official language in Botswana therefore having being through the education system in Botswana and a professional, the researcher's spoken and written English are fluent and clear. Being a native Motswana who has been born and raised in a Setswana speaking family and community, the researcher speaks fluently and writes clear Setswana language. This could also be argued to have placed the researcher at an advantage in terms of access to the research participants, due to having a relatively common history and cultural traditions.

Secondly, but equally important, engaging a translator would have been costly for the researcher who had a tight budget in terms of time as data was collected from Botswana, thousands of miles away from Wales, within three months. Therefore, the money would have been needed to finance the qualified translator for this research.

Lastly, the data was collected within a limited period of time therefore the data was collected in Botswana while translation process was completed in Wales where the chances of getting a translator with the linguistic strength required for this study was almost non-existent.

During the translation process it is of great importance that the meaning of the data be understood clearly by the translator, failure would render the data useless and hence lost.

The researcher acknowledges that the translation process was not an easy task, as was evident in this study; it posed some challenges as outlined in the next section.

b. Challenges of translating interviews

Language is more than the medium people use to express what they want to say. Research participants use it to construct, as well as structure their accounts to present themselves in particular contexts.

> "Personal narratives are the outcome of the process that the teller remembers, interprets, constructs, and reconstructs events in the outside world which have been subjectively experienced, events whose meanings are constructed using the language, discourses, and discursive strategies which are available to the teller." (Temple 2008: 356).

Therefore, there is a need for interview data to be translated in such a way that the meaning of the data be understood clearly by the translator. Translating words and concepts that define experiences for which there is no true equivalent within the target language was a challenge in this research. In addition the idea that words evoke experiences rather than contain meanings had implications in translating accounts through language. During the process of translation, the researcher/translator relied on personal interpretation by putting the words into context of the interview questions. However, studies by Esposito, (2001), Twinn (1996), has indicated that personal interpretation of data could have implications on the themes generated from the translated data for analysis at a later stage. During translating process, the researcher identified that not all concepts were universal and therefore not everything was translatable hence some aspects may have been lost in the process if an equivalent word was not found.

There was a tendency of some element of 'dross' in translating the data. Twinn (1996) defines 'dross' as a dialogue that wanders from the topic of discussion, presenting data that were not particularly usable in the interview. For example, some participants were more interested in giving an account of their general life problems largely not related to the challenges HIV have brought to their lives as per the objectives of the study. Such accounts are the ones referred to by Twinn (1996) as 'dross' and therefore may be lost during translation and transcribing process.

The differences in grammatical structure between the source language (Setswana) and the target language (English) added to the complexity of the translating process for the researcher in attempt to developing an accurate representation of the narrative, which may eventually contribute to the analysis of the data. The choice of some words used by the interview participants was confusing during translation, particularly where 'slang[48]' and words with deep meanings were used. It was therefore necessary to understand the local syntax. In cases where the translator did not have the equivalent word, assistance was requested from other people who spoke the local language, and this obviously poses an impact on the reliability of the data.

The bilingual usage of Setswana and English was common, even though it was anticipated, among the interview participants. A large number of people in Botswana speak English as an official language and Setswana as a local language; therefore there is a common culture of importing some English words into Setswana conversations. This was found to be challenging during translation particularly where the English words were not used in context and hence lost their true meaning. However, when used appropriately and within context, the multi-usage of the two languages aided the process tremendously as translation would be done precisely.

During the interview, the researcher occasionally used English phrases rather than Setswana to clarify some points, issues and questions which were difficult to translate clearly to the local language. Twinn (1996) referred that process as 'shorthand' and noted that if these phrases are not used consistently throughout the interviews they may have an impact on the reliability of the data. These phrases may also lose the meaning and pose the risk of miscommunication if the interview participant is less conversant with English language, however in obvious cases the researcher repeated the question in Setswana therefore the version that finally got translated will be the one where the participant seemed to be in context with the topic of discussion.

The entire process of translating the interview was time consuming and tedious however the researcher's goal was to develop transcripts that are accurate, clear, sound and as

[48] Some interview participants used some informal language known as 'slang', to express themselves and relate their experiences. Some such words have no true equivalent in the English language.

natural as possible. The researcher acknowledges that there is a potential for translation error in cross-cultural research at all phases of the research as noted by Esposito (2001). It was therefore important to remain as close to the original meaning as possible while making the translated transcripts comprehensible.

In a nutshell, despite all the challenges, the translation process yielded rich data that will help this study enormously.

4.9 Observation

Making observations on the houses the people live in provided the study with valuable information and an account on housing quality and conditions of housing occupied by poor people living with HIV/AIDS. Observing the housing structures also presented a good avenue in threefold: to support what has been reported during the interview, to validate the data gathered in the interview and to visualise the houses being discussed during interviews. For example, one of the interviews indicated that they lived in a three roomed shack wholly constructed with corrugated iron sheets. The explanations given during the interview could not capture the picture and hence the observation was very useful on this account. Nonetheless, not all the interviewees authorised the physical observation of their housing for personal reasons but those who allowed access facilitated the provision of valid data.

4.10 Documents and Policy Analysis

Secondary data search from official records including national policies on lands, housing and destitute policy were also analysed. These policies assisted in complementing and validation of the data derived from the primary data source which was through the interviews. The legal documents were analysed specifically to extract and identify policy factor and other emerging themes of interest for illustration and to complement the interview data. Official reports, such as budget speech, president's state of nation addresses and policy reviews, were used to complement the interview data.

Other corroborating evidence emerged from unplanned and unexpected sources such as the media, including local newspapers, and the researcher's inquiry on mortgage lending with

the commercial banks which the researcher visited for personal insight into housing finance for low income people.

4.11 Data Analysis

This section discusses methods and techniques that are employed in the data analysis process, often explaining the reason for adopting the techniques, difficulties encountered, and the likely effects of the data analysis process. Since most of the data accumulated in this study was largely qualitative in nature, the data was subjected to qualitative methods of analysis. Qualitative research often yields large volumes of unstructured data that requires a structure to help in its analysis.

4.11.1 Analysing Qualitative Data

The actual process of analysing qualitative data involves organising data in a way that allows for distinct patterns and concepts and subsequently theoretical stances to be formed after some systematic process. A large amount of data was collected during field study hence it was necessary to be selective as a way of maintaining clarity of meaning from the available data while at the same time taking advantage of the density of data available to the study.

In qualitative research, data collection and analysis takes place simultaneously. Based on that understanding, data analysis commenced from the onset of data collection and continued throughout the data collection stage as the researcher formed and altered impressions and ideas on the issues and ideas raised by the interview participants. The transcription of the interviews allowed for reflection on the content and meaning of data, and therefore became yet another phase in the data analysis process.

4.11.2 Coding the Data

Having transcribed interviews and collected various policies and documents, the data was then sorted according to its nature and content. Thereafter the analysis process started in earnest. In analysing the data for this study, the researcher was guided by methodological and analysis methods advanced by Silverman (2005) and Bryman (2004) who suggest that data analysis consists of three concurrent flows of activity: data reduction, data display and conclusion/drawing verification. Having that understanding, the researcher acknowledges

that coding the data contributed to the data reduction process. Creswell (1994) observed that during the code development phase, the researcher takes a large volume of information and reduces it to patterns, categories, themes and then interprets this data to answer the research objectives. Furthermore, Bryman (2004) presents coding as the key process of grounded theory. The coding process involves reducing the amount of data by sorting and labelling it into component parts that seem to be of potential significance to the study objectives. Although these codes serve as potential indicators of themes and concepts to emerge from the data, Bryman further observed that the codes are tentative and in potential revision and fluidity during the process of data analysis.

The first critical step of data in data reduction involved extensive reading through transcripts, noting major themes that appear in the respondents' accounts and building categories about the data. At this early stage in the analysis the categories developed were very basic and largely informed by ideas that the researcher had generated during the data collection and which were seen as recurring in the data. The recurring ideas in the data also facilitated in the generation of initial development of major codes.

Once the major categories were identified, all the transcripts were imported into the computer software package QRS Nvivo 8. The data was partially managed using the computer software mainly because it enhances the recording and storing of data, filing, coding and retrieving data making it easier for the researcher to analyse the data (Dey, 1993). According to QRS (2007), the Nvivo software is designed to help manage, shape and make sense of unstructured information by providing a workspace that enables to work through difficult and complicated data. It assists in analysis of data materials, identify themes, glean insights and develop meaningful conclusions. However, the software was used mainly to code and store the data into themes (free nodes) and sub-themes (tree nodes). QRS Nvivo allowed the researcher to identify text segments and attach category labels to text, re-code and sort all text segments according to specific themes. These functions were particularly helpful as they allowed the researcher to see clear patterns of common or differing perspectives among the different respondents in the data. For example, the main theme on common housing problems faced by PPLWHA was identified: this theme was drawn into proposition of sub themes including: the factors contributing to the housing problems; responses to the housing problems for PPLWHA; impact of the problem on the health of PPLWHA; involvement of the housing stakeholders

in addressing the problem etc. As the process of coding advanced, new themes emerged and some old themes were merged together further reducing the codes hence generating smaller units of analysis. QRS Nvivo assisted the process substantially by its ability to effectively manage data allowing the researcher to manipulate, re-arrange, re- classify sort it in different ways. Although the researcher had limited training on the use of Nvivo software, something that hampered the maximum benefit and assistance of the software in data analysis, the study used the software as much as possible. Ultimately, the rest of the data was manually analysed to prepare it for interpretation.

The next step in the data analysis involved interpretation of the coded. This is often a challenging process to discover as the researcher is involved in a creative process whereby meaning was given to code data.

This was done by re-reading the themes and sub-themes generated from QRS Nvivo several times while noting further emerging issues, similarities and differences between case studies. Once the themes, sub-themes and patterns were established, the data was then ready for presentation and discussion in chapter 5 and 6.

4.12 Summary and Conclusion

This chapter provided an extensive description of the methodology and methods used in this study. It started by outlining the primary aims of this research and continued to further outline the research questions and sub- dividing them to form research sub-questions which are more specific and will be adopted to achieve the main aim of the study.

The chapter then moved on to assess several theories that are used in housing research but ultimately presented critical realism as a theory suitable to assess the problems and constraints that contribute to housing for PPLWHA. This was based on the key assumption of critical realism that reality is not merely observable but comprises several interconnected domains of the real (process, structures, powers and causal mechanisms that generate events) actual (events which may be either observable or non-observable) and the empirical (which involves experiences and events through observation, explaining any observable to the underlying unobservable structures). In line with the critical realism theoretical stand point, case study method was presented as the suitable data collection method used in this study. The chapter advanced the case study's strength of having the

ability to investigate naturally occurring cases, which also allows for the holistic investigation of real life events as key and useful to this study. This is because the case study method, in addition to critical realism theory, aim to get informative insights that capture the phenomenon under study well enough to reflect the general, typical and logical occurrence in order to facilitate transfer of the findings rather than being representative of the entire sample, hence the small sample size in this study. Data was collected from a total of 45 people through the use of semi structured interview method. The primary aim to assess the factors, structures, powers and causal mechanisms that generate and contribute to the housing problem for PPLWHA from the accounts of the housing policy makers, the housing service providers and the housing consumers affected (PPLWHA). Although access to the study subjects, particularly PPLWHA presented some challenges, great assistance was achieved through the use of key informants which helped the study to achieve a relatively good sample size as a total of 26 PPLWHA were recruited to participate in the study. This chapter has discussed the entire process of data collection from access to the study subject to translation and transcribing of the data. It highlighted the challenges presented during the data collection period as well as ways that were undertaken to address the problems. Although transcribing and translating the interviews from local language to English was a challenging experience for among other reasons being a costly and time consuming exercise, it yielded rich qualitative data. Since qualitative data requires to be organised in a logical manner to be able to be transformed from individual accounts into patterns, categories, themes that are eventually interpreted to answer the research objectives, the final section of this chapter described how the data was analysed. The data analysis was primarily done through the use of the computer software package, QRS Nvivo 8, which is designed to help manage, shape and make sense of unstructured information by providing a workspace that enables one to work through difficult and complicated data. The software package assisted in analysis of data materials by identifying themes, gleaning insights and developing meaningful conclusions out of the data. The next chapter will present and discuss the empirical findings of this study, primarily focusing on answering the research questions

CHAPTER 5: HOUSING CHALLENGES AND CONSTRAINTS FOR PEOPLE LIVING WITH HIV/AIDS

5.1 Introduction

This chapter is the first of two chapters presenting the empirical findings. This chapter will discuss the housing problems faced by PPLWHA in the different housing tenures they live in. The role of the various factors, mechanisms and structures directly and indirectly associated with housing will be considered to outline their contribution to the conditions of housing and ultimately the health of PPLWHA. The discussion will be based primarily on the narratives of the in-depth interview data collected from 26 PPLWHA of which 25 were female and one was male. Data from secondary data sources such as housing and lands policy documents as well as literature from other research studies will be used to complement the interview data where and when necessary. Chapter six will present the responses from the various governmental and non-governmental organisations to the housing problems faced by PPLWHA.

Chapter 2 of this study revealed that housing, or rather lack of adequate housing, is powerfully linked to the exposure to risk and transmission of HIV, as well as to the management and care of poor people living with HIV/AIDS. Improvements in housing are therefore associated with reduced HIV risk and improved health care outcomes. This chapter will outline how provision of affordable sanitary housing in Gaborone could play a critical role in the health PPLWHA.

This chapter will be divided into four sections as outlined below: Section 5.2 will be a descriptive background section that will lay a foundation for this chapter. Prior to outlining the housing challenges, it is important to establish the various housing tenures that are commonly held by PPLWHA, as well as make an evaluation of the housing and living conditions and other factors that are apparent in their specific housing tenures. This will be beneficial in that it will provide a foundation for the discussion of the housing problems faced by PPLWHA in the light of the conditions, the mechanisms and structures

surrounding the specific housing tenures that are in common use by all the 26 PPLWHA in the sample.

Section 5.3 will analyze the various housing problems faced by PPLWHA by using the three domains of critical realism theory being: the real, which consists of process, structures, powers and causal mechanisms that generate events; the actual, which relates to activation of events which may be either observable or non-observable and consist of underlying mechanisms or structures, which tend to have influence in favourable circumstances; and the empirical, which involves experiences and events through observation and gives the opportunity to explain any observable effects with reference to the underlying unobservable structures. These three domains will be used to analyze how the various structures and mechanisms interact and ultimately produce or contribute to the housing problems and constraints experienced by PPLWHA. The section will also analyze how the housing problems faced by PPLWHA exacerbate their HIV/AIDS problem through evaluating the formal and informal strategies that PPLWHA adopt in an endeavour to deal with their housing problems. The various factors that encourage or constrain the PPLWHA to adopt strategies they use to support their individual housing needs will be identified. The section will also analyze the implications the adopted strategies have on the HIV/AIDS condition of PPLWHA.

Section 5.4 gives the summary of the key points of the chapter and Section 5.5 draw conclusions on the chapter through demonstrating how and why the various structures and mechanisms interact and eventually support or exacerbate HIV/AIDS problems for PPLWHA through housing in direct and indirect ways.

5.2 Housing Tenure and Dwelling Form: An Overview

In order to understand what the housing problems of PPLWHA are it is necessary to distinguish the various types of dwellings that are used by PPLWHA in this study, based on the assumption that the housing quality and conditions that are apparent in the dwelling forms used by the PPLWHA has an influence on their health.

Kumar (2001) observed that cities in developing countries are home to a heterogeneous mix of tenures: owners, landlords, tenants and sharers. The dwelling forms that I have distinguished here are based on the empirical observations I made during fieldwork of this

study and are influenced by the approach adopted by Rex and Moore (1967). In their studies of Birmingham, Rex and Moore posit that there is a class struggle over the use of houses in the city which is evidenced by the presence of many potential housing classes and the various kinds of access to the use of housing in cities. Based on that and for a clear presentation of the low income housing consumption, I have identified three distinct dwelling forms that PPLWHA use to access housing in Gaborone and they are sorted according to tenure type:

1. Rental dwellings
2. Rent free dwellings
    a. Living in Family home
    b. Living with boyfriend/partner
    c. Living in temporary shack[49] in family plot
3. Owner occupation

Evidence was gathered from 26 cases documented in interviews with PPLWHA, and it indicated that PPLWHA access housing through a combination of tenures as summarised in Table 5.1

Table 5.1: Summary of housing tenure alternative

Tenure Type		**Total Number of Participants**
Renting		7
Rent free	Family Home	8
	Partner/boyfriend's house	2
	Temporary Shack	2
Owner Occupation		7
Total		**26**

Source: Authors' compilation

[49] A Shack is a temporary housing structure (shelter) that does not meet any of the conditions of the building control regulations constructed almost entirely from non-durable materials such as plastics, old sheeting materials. Usually shacks have makeshift foundations and lack proper doors and windows.

To be able to contextualise the housing experiences and housing challenges faced by PPLWHA, the next three sections will present and discuss the three specific housing tenures: rental, rent free and ownership tenures respectively describing the housing conditions that PPLWHA live in within each of the tenures before going on to discuss the problems that these housing conditions could pose on the health of PPLWHA.

5.2.1 PPLWHA living in rental dwellings

Urban shelter has become a problem in most cities in developing countries around the world although the housing problem is more visible among the poor people. The majority of poor people don't only require housing but need affordable and sanitary housing (Peng, 1989; Datta and Jones, 2001). Most of PPLWHA in this study who were in rental housing indicated that they were renting due to affordability constraint rather than through choice, particularly that they have household priorities more pressing than home ownership, a concern that has also been observed by UN Habitat who wrote:

> "A significant proportion of the world's urban poor are not able to afford property ownership, therefore, rental housing is the most logical solution for these households." (UN-Habitat 2003: xvii)

Table 5.2 presents the profile of all the seven PPLWHA from the sample of this study who lived in rented housing in the low income rental housing market.

Table 5.2: Profile of PPLWHA in informal rented housing

CASE	AGE	MARITAL STATUS	SOURCE OF INCOME	MONTHLY INCOME	LOCATION	HOUSING TYPE	RENT PRICE	TOILET	PEOPLE SHARING BEDROOM WITH PPLWHA	NO OF PEOPLE ON PLOT
6	33	Single	Employed	P1500+	Gaborone periphery	Two-roomed house	P500	Shared pit latrine	1	10+
7	26	Single	Employed	P750	Gaborone periphery	Multi-purpose room	P400	Shared pit latrine	2	10+
11	30+	Single	Occasional part-time jobs (boyfriend support	P200	Gaborone periphery	Multi-purpose room	P200	Shared pit latrine	1	10+
15	35	Single	Volunteer (friends and family support)	0	Gaborone (SHHA)	Multi-purpose room	P200	Shared pit latrine	0	10+
16	50	Single	Informal shebeen	P250	Gaborone (SHHA)	Multi-purpose room and shack	P150 room and P50 shack	Shared pit latrine	2	Many
17	37	Single	Unemployed (live-in employed boyfriend)	0	Gaborone periphery	Multi-purpose room	P250	Shared pit latrine	1	8
24	24	Single	Employed and informal landlord	P1250	Gaborone periphery	Multi-purpose room	P150	Shared pit latrine	0	Many

Source: Authors' compilation. NB: All PPLWHA in the rental market as tenants were female.

Renting was common among the middle aged single women in their 30s with an exception of one who was in her 50s. This corresponds with Kumar (2001) and Datta (1996) who observed that renting is usually common among women headed households in their early stages of their life cycle.

The low income rental housing market provides a wide variety of rental accommodation not only to PPLWHA but to the poor people in general ranging from renting one of the following:

i. **The entire house** - None of PPLWHA rented the entire house although they are available in the low income rental market.
ii. **A single multipurpose room** - arranged in a hostel type (a row of single rooms) and are popularly known as 'rooming'. Most of these rented rooms are usually located at the back of the plot behind the main house[50] that is normally used by the landlord, such as those in Figure 5.1.
iii. **A part of a room** - This is renting a part of space within a single room, shared by several individuals who are unrelated and had no prior knowledge of each other, supposedly living independent of each other in a shared room. This could be attributed to an influx of immigrants[51] who are visiting the country for a short period of time and need temporary and cheap shelter.
iv. **A temporary housing structure commonly known as a 'shack'** - commonly practised by poor people who find it difficult to afford even the cheapest of the cheap houses in the housing market therefore, resorting to live in poor quality temporary shelters built informally with non-durable materials (Kalabamu, 2003; Gwebu, 2003).

PPLWHA in rental tenure were especially in SHHA areas in Gaborone although some lived in villages within the city's periphery. The high demand for low cost accommodation

[50] Main houses in this study refers to primary housing structure on a plot which is built according to the approved house plan and adhered to the building control and regulation measures. Figure 5.1 is an example of the main house at the front while several rented rooms are built at the rear of the same plot. Due to adherence with the regulatory measures, the quality of the main house is usually better than the rented rooms in terms of the building materials used, utilities provided and the average space area provided for occupation per person.

[51] Political and socio-economic situation in neighbouring countries, particularly Zimbabwe, have resulted in an influx of illegal immigrants into Botswana. These immigrants among other basic needs seek shelter, consequently increasing the already high demand for low income shelter in the country.

in Gaborone have pushed the poor people to resort to the cheap rental housing market, particularly in villages within the periphery of Gaborone as reflected in Table 5.2

5.2.2 PPLWHA Living In a Rent-Free Dwelling

Studies have revealed that some of the poor people find the formal rented housing market expensive and unaffordable and therefore inaccessible to them. Consequently they resort to alternative ways to acquire inexpensive routes to satisfy their housing need (Datta, 1995; Booysen and Bachmann, 2002; and Precht, 2005). In this study, shared housing was reflected to play an important role not only to people whose age and income suggest that they are at an early stage of their housing cycle where flexibility counts most but mainly to those who need social, emotional and economic support from their family members during the time of need and illness.

The data reflected that PPLWHA lived in three various types of setting which was shared and mostly rent- free as outlined below and summarised in Table 5.3 below.

i. Sharing with a partner/boyfriend: some female PPLWHA have become dependent on male partners in order to satisfy their housing need.
ii. Living in a family home - kinship relations in a context of an acute housing need and in time of illness are particularly important as it provides the social, emotional support and housing support.
iii. Living in a rent free temporary shack in other peoples' plots: some of the poor people find it difficult to afford even the cheapest of the cheap houses in the housing market therefore they resort to living in poor quality temporary shelters known as shacks built informally within the formal SHHA.

Table 5.3: Profile of PPLWHA who lived in various rent free dwellings

CASE	AGE	MARITAL STATUS	SOURCE OF INCOME	MONTHLY INCOME	LOCATION	TOILET	HOUSING TENURE	HOUSING TYPE	NO. OF OWN CHILDREN (AGE/S)	NO OF PEOPLE SHARING BEDROOM WITH PPLWHA	NO OF PEOPLE ON PLOT
20	27	Single (engaged)	Volunteer	P210	Periphery	Pit latrine	Boyfriend's parental home	Multi-purpose room	3 (10,8,2)	4	15
25	46	Single (long-term partner)	Unemployed	0	Periphery	Water system	Partner (boyfriend)'s home	Two bed modern house	2 (27, 22)	1	5
13	46	Single	informal shebeen	P250	Gaborone	Pit latrine	Family home	Multi-purpose room	6 (29,26,23,18,17,13)	8	40+
10	37	Single	Employed	P350	Periphery	Pit latrine	Family home	Three bed modern house	1 (7)	3	13
19	31	Single	Volunteer	P210	Periphery	Pit latrine	Family home	Two and a half house	1 (10)	7	18
9	34	Single	Employed	P750	Periphery	Pit latrine	Family home	Multi-purpose room	0	0	8
5	37	Single	Unemployed (family support)	0	Periphery	Pit latrine	Family home	Multi-purpose room	2 (n/a)	0	7
3	35	Single	Unemployed (family support)	0	Periphery	Water system	Family home	Three bed modern house	1 (14)	1	7
8	32	Single	occasional part-time jobs, informal landlord	P1500+	Periphery	Water system	Family home	Three bed modern house	4 (18,13,5,4)	2	9
4	36	Single	Unemployed (family support)	0	Periphery	Pit latrine	Family home	Two and a half house	2 (12, 16)	2	12
26	40+	Single	Volunteer	P510	Periphery	Pit latrine	Friend's plot	Temporary multi-purpose shack	1(19)	3	4
18	25	Single	Volunteer	P210	Periphery	Pit latrine	Friend's plot	Temporary multi-purpose shack	2 (6,3)	2	5

Source: Authors' compilation

5.2.3 PPLWHA who are owner occupiers

As families gets older (in age), independent, accumulate savings and increase in size, they tend to be attracted to investing in valuable resources such as a home (Gilbert, 1983). Owner-occupation in this study was common among PPLWHA middle age people with a relatively stable source of income. However, home ownership in this study was exclusively located in peripheral villages where residential land is freely allocated to qualifying citizens and the building regulations are not strictly enforced as in the urban areas. Table 5.4 gives a summarised profile of all PPLWHA in owner-occupation tenure

Table 5.4: Profile of PPLWHA in owner occupation dwellings

CASE	GENDER	AGE	EDUCATION LEVEL	NO OF OWN CHILDREN (AGE/S)	MARITAL STATUS	SOURCE OF INCOME	MONTHLY INCOME	LOCATION	TOILET	HOUSING TYPE	NO OF PEOPLE SHARING BEDROOM WITH PPLWHA	NO OF PEOPLE ON PLOT
1	Female	40+	Junior Secondary	2	Single	Employed	P2500+	Periphery	Pit latrine	Two-roomed mud house	0	2
2	Female	40+	Primary Education	1 (19)	Married	Employed	P510	Periphery	Water system	Two-bed roomed house	1	3
12	Female	50+	Junior Secondary	1 (28)	Married	Volunteer	0	Periphery	Water system	Two and a half house	1	2
14	Female	51	Primary Education	1 (29)	Divorcee	Volunteer, informal shebeen, informal landlord	P500+	Periphery	Pit latrine	Two-roomed house	0	11
21	Female	34	Primary Education	0	Single	Volunteer + informal landlord	P210	Periphery	Pit latrine	Partially complete three bed modern house	0	11
22	Female	45	Primary Education	6 (23,19,14,11,9,6)	Single	Part-time jobs and informal landlord	P1000+	Periphery	Pit latrine	Two and a half house	4	30+
23	Male	50	None	7 (not known)	Single (long-term partner)	Unemployed, informal landlord (family support)	P250	Periphery	Pit latrine	Two and a half house	3	12

Source: Author's compilation

5.2.4 Housing Conditions of PPLWHA's Dwellings: an Overview

In an attempt to address research question 1, which seeks to explore how the housing and environmental conditions contribute to the health of PPLWHA, it is important to have an overview of the conditions of their dwellings as well as the environment surrounding the dwellings. PPLWHA lived in dwellings that vary in structural quality and condition within and between tenures. Based on the empirical observation of some of the dwellings used by the PPLWHA that I made during fieldwork and adopting the approach by Gwebu (2003), who used the Statutory Development Control Code[52] to categorise the rooms (by structural quality) usually found in the low income housing rental market within the SHHA areas of Gaborone into three broad qualities namely-good, medium and low quality room-I also categorised the dwellings used by PPLWHA into the three groups as discussed below in turn.

1. The good quality rooms are commonly constructed in accordance with the building control regulations which state that they have; a proper foundation, walls constructed from concrete bricks, a roof made with galvanized zinc and are fitted with conventional doors and windows in the correct positions, such as the one in Figure 5.1. The rental price for these rooms is however relatively high[53] as the rooms are highlighted by PPLWHA to be relatively comfortable due to their structural quality and the utilities provided such as electricity.

[52] The Statutory Development Control Code is intended to regulate building construction in SHHA areas ensuring that there is a measure of safety, health, amenity, access and hygiene as well as ensuring that the land will maintain its value. However, most structures in the old SHHA areas in Gaborone have not adhered to these building control and regulation measures (Gwebu, 2003)

[53] The high price mentioned here is relative to the rental prices in the low income housing market.

Figure 5.1: An example of good quality rented multi-purpose rooms

Rented rooms are situated behind the main house. Households share communal space such as the drying line and the pit latrine as shown in the picture

Source: Taken by Author (2008)

2. The medium quality rooms are partially completed and usually they did not meet all the requirements of the Building Control Regulations; for example, they may not have proper doors, windows and the walls may not be plastered or painted although they are used for shelter such as the room in Figure 2. The rooms have neither electric power connections nor roof ceilings, which make them very cold and humid in winter; and extremely hot in summer. All PPLWHA living in single rooms reported that they used the room for all activities including sleeping, bathing, cooking and resting.

Figure 5.2: An example of medium quality rented multi-purpose single rooms.

Households share communal and the pit latrine usually situated at the rear of the plot
Source: Nkwae and Dumba (2010)

The medium quality rooms were commonly used by PPLWHA and their popularity could be related to their rental price, which is relatively "affordable" to the income of most PPLWHA in this study coupled with the desperate need for cheaper accommodation rather than the comfort, safety, and the quality of the room structure.

3. The low quality rooms are temporary structures and do not meet any of the requirements of the building control regulations. The rooms usually don't have a foundation, the walls are constructed with a variety of non-durable materials such as mud, poles, cardboard boxes, metal sheeting and plastics and they don't usually have either proper doors or windows. An example of a temporary shack is shown in Figure 5.3.

Figure 5.3: An example of medium quality rented room (two brick-walled rooms) and a low quality rente temporary shack
Source: Taken by Author (2008)

All PPLWHA living in single multi-purpose rooms indicated that they used the room for all activities including sleeping, bathing, cooking and resting.

Although PPLWHA lived in rooms of varying qualities, they experienced relatively similar problems ranging from: social problems related to sharing plots and rooms; economic problems related to poverty and affordability; environmental health problems related usage of poor housing structures; overcrowding of people and structures on the plot; and politically related problems related to access to housing and housing related services. All these problems will be discussed in section 5.3 when analyzing the various housing problems faced by PPLWHA that became apparent from this study.

5.3 Housing Problems Faced by PPLWHA

This section will analyze the various housing problems faced by PPLWHA by using the three domains of critical realism theory being: ***the real***, which consists of process, structures, powers and causal mechanisms that generate events; ***the actual***, which relates to activation of events which may be either observable or non-observable and consist of underlying mechanisms or structures, which tends to have influence in favourable circumstances; and ***the empirical***, which involves experiences and events through observation and gives the opportunity to explain any observable effects with reference to the underlying unobservable structures. These three domains will be used to analyze how

the various structures and mechanisms interact and ultimately produce or contribute to the housing problems and constraints experienced by PPLWHA. The section will also analyze how the housing problems faced by PPLWHA support or exacerbate their HIV/AIDS problem. However, it needs to be acknowledged that besides HIV/AIDS pandemic, the country suffers from other problems including poverty and unemployment which have the potential to intensify the problem of those faced not only by the aforementioned problems but also infected with HIV. Therefore, guided by this contention, the issue of provision of adequate shelter for poor people living with HIV/AIDS should not be viewed in isolation but rather be seen in the context of these other problems.

Housing problems experienced by PPLWHA are varied and most of them are linked to poverty, affordability and accessibility to safe and sanitary housing and related services. Based on the assumption that HIV/AIDS is a major factor on their lives and therefore has the potential to influence the socio-economic problems and constraints PPLWHA experience, PPLWHA were asked to discuss the housing problems they experience in the light of HIV/AIDS. In response, they pointed out various issues and concerns which are summarised into these five sections:

1. HIV/AIDS is perceived as a secondary problem by PPLWHA.
2. Poverty is fundamental to the housing choices and decisions PPLWHA have.
3. There is lack of affordable sanitary housing for PPLWHA.
4. Vulnerability of PPLWHA to housing tenure insecurity.
5. Housing finance is inaccessible and unaffordable to low income people.

The findings highlighted that there is a combination of real and actual structures that interact with one another to influence and contribute to the housing problems faced by the PPLWHA. Based on critical realism theory which underpins this study, the real can be described in terms of its structure of causative powers. As Williams (2009) contends, real things have causal properties although some objects possess greater causal efficacy than others. HIV/AIDS and poverty are two structures that can be identified as real phenomena that are undoubtedly a challenge in the lives of PPLWHA hence in the 'real' domain of the critical realism framework discussed in Chapter 4 (Figure 4.1). The two phenomena will be discussed below in turn.

5.3.1 PPLWHA perception of their HIV Status

The literature review on HIV/AIDS has reflected that poverty and HIV/AIDS are interrelated: as such, the drain of HIV/AIDS to the household economies was expected to be highlighted by the respondents as the main factor contributing to their housing problems. However, and contrary to the literature most PPLWHA emphasised that despite being HIV positive, they don't feel the impact of HIV/AIDS on their daily lives but rather find poverty and their economic hardship more of a problem to them than HIV/AIDS. When asked to outline their perception of HIV/AIDS on their housing problems, some PPLWHA had this to say:

> "I am not sick at the moment; I am just a carrier and not even on ARV. My problem is lack of employment due to lack of qualifications and experience required by the employers. I can do any work available although I am HIV positive" (Peo, aged 27 and not on ARV).

> "My main problem is the poverty I am in and not my health. My HIV status doesn't hinder me at all... "(Tebogo, aged 35 and on ARV)

These statements reflected that PPLWHA don't consider their HIV status as their major concern but view poverty as the primary cause of their housing problems. The policy makers shared the view that corresponded to those of PPLWHA: One of the policy makers commented:

> "The problems of housing are due to poverty.....HIV problem is a contributing factor but I personally believe that the root cause is mainly poverty. The problem of housing becomes worse for a person who is infected and is poor or is a destitute already, in that case the situation turns into a crisis (Principal Social Worker, Destitute Housing Division)."

Before proceeding to analyse poverty as a key housing problem to PPLWHA, it is important to consider three key factors that emerged from the statements made by PPLWHA that have contributed to their perception of HIV/AIDS as only a minor problem.

Firstly, the statements reflect that PPLWHA who have accepted and embraced their HIV positive status into their daily lives are optimistic about their HIV status as is evident from their perception about their HIV health status. At the time of the study, all the 26 PPLWHA in the sample were only HIV positive and not yet developed into AIDS patients. All of them were open about their HIV status and were willing to discuss it publicly, an indication that they have accepted and embraced their HIV positive status in their daily lives and to a larger extent living positively with it. However, it is beyond this research to discuss the behaviours and attitudes of PPLWHA in that respect.

Secondly, the statements concur with the view that being HIV positive does not necessarily mean the HIV infected person is sick and incapacitated but rather that a person has a health condition which will ultimately develop into a disease that will make an HIV positive an AIDS patient, as it has been discussed in chapter 2.

Thirdly, the data reflects that the administration of free ART to HIV positive people and the AIDS patients have an influence on how PPLWHA perceive HIV/AIDS. Among PPLWHA, there were those who were enrolled on the ART programme as outlined on Table 5.5. While acknowledging that ART does not cure HIV/AIDS but is a treatment or therapy that delays the onset of AIDS.

Due to that ART programme, a high percentage (69%) of PPLWHA indicated that they were enrolled on the programme as outlined in Table 5.5.

Table 5.5: The summary of PPLWHA's ART usage

Number of People on ART		**Employment**	
Yes	18	Yes	11
		No	7
No	8	Yes	7
		No	1
Total	26		26

Source: Authors' compilation

The administration of ART for free to qualifying citizens is one of the measures that the Government of Botswana has currently engaged in responding to HIV/AIDS and it is undoubtedly being appreciated by PPLWHA. However, the immediate positive effects of ART have manifested themselves on the health of PPLWHA using them by improving their health, consequently overshadowing the long term health implications of HIV on the lives of PPLWHA. As a result of the current good health, PPLWHA have normalised their HIV positive status and have shifted their focus off HIV onto the other problems such as

the economic hardships they currently face. This is parallel to Alder (1999)'s observation that the poor are more concerned about problems which impact directly on their ability to earn a living which by implication means that it is usually difficult for the poor to look beyond their current situations.

Although PPLWHA considered HIV/AIDS as a minor problem largely due to the profound positive effect of ART, their socio-economic problems are still outstanding and poverty is evident in their daily lives.

It appears appropriate to note here that the future administration of free ART in Botswana may be uncertain even though the benefits of the current programme are impressive to PPLWHA. One of the Botswana Cabinet Minister recently commented, as quoted by a local newspaper:

> "....it is not certain that the Government may continue providing ARV for free forever as the economic situation continues to change." (Botswana Daily News, 16.02.2010)

By implication, this highlights that the sustainability of ART in Botswana is uncertain due to local and global changes such as economic decline. In the event that the free ART programme is disrupted, the impact will be felt more and foremost by PPLWHA as they will definitely be at a disadvantaged position to afford the ART at personal level (for lifelong adherence) due to their already established poverty and economic problems. This will then alter the lives of PPLWHA tremendously including affecting the perception they currently have about being HIV positive.

5.3.2 Poverty is primary problem to PPLWHA

The data highlighted that poverty is pronounced and widespread among PPLWHA although the extent and circumstances vary among the individuals. Poverty was assumed to be an outstanding structure that possesses some causative powers to the housing problems of PPLWHA mainly because this study is particularly focused on the people who are not only poor but also living with HIV/AIDS. The PPLWHA confirmed this assumption by unanimously pointing out poverty as a principal problem in their lives.

Section 5.1 has provided a snapshot of the poor housing conditions that are faced by PPLWHA, which are a clear indication that PPLWHA are experiencing housing poverty despite the assumption that improved housing contributes to positive health outcomes

(Goebel, 2007: 299). Drimie (2002) observed that the intensifying responses to the HIV/AIDS epidemic by governments, particularly in developing countries, have focused more on treatment (especially on ART), prevention and care and have therefore tended to ignore the broader picture of the implications for poverty reduction. Consequently the PPLWHA, as already indicated experience the impact of poverty more than the impact of HIV, even though the two are closely related.

In addition, most of PPLWHA in the study reflected that they experienced some income poverty which was evidenced by the fact that among the 26 PPLWHA, only 5 had formal employment which provided them with a regular source of income, 13 people were involved in various income generating activities and part-time jobs which are irregular and provide meagre income to cater for their basic needs while 8 were unemployed and had no formal source of income consequently depending entirely on family and friends for provision of basic needs.

Table 5.6 gives a summary that highlights the monthly income of PPLWHA in this study to give the picture of the income base that they have to cater for all their basic needs some of which include paying for accommodation.

Table 5.6: Summary of income for PPLWHA	
Monthly income range in Pula (P[54])	**Number of PPLWHA**
0	8
1 – 250	6
251 -500	3
501 – 750	4
751 – 1000	0
More than 1000	5
Total	**26**

Source: Authors' compilation

It has been outlined that the impact of HIV/AIDS can impoverish people in such a way as to intensify the pandemic itself (Whiteside, 2002). The deterioration in health of some of PPLWHA has been reflected to have contributed to a steady drain on economic resources as was highlighted by two PPLWHA who reported that although they were self-supporting their families before they were diagnosed HIV positive, currently they did not have any source of income as they are constantly ill hence they find it difficult to engage in the employment market or income generating activities to help maintain their health, basic needs and their housing as one outlined here below:

> "I live on my own plot in a two and half roomed house which I built before I was sick from my personal savings. I live with all the seven children and three grand children in the

[54] Pula (P) is the currency of Botswana. The exchange rate at the time of the fieldwork (2008) was 1 Sterling Pound was approximately 12 Pula (P12).

At the time of fieldwork, P12 could buy two loaves of bread, or a small bag (500g) of sorghum -meal, the staple food, enough to feed four people in a day.

Currency converter used can be found at http://www.gocurrency.com/countries/botswana.htm

> house. ...before I got sick I was actively engaged in casual jobs which gave me enough money to develop the two and half house that we currently live in. At that time, it was easy because things were relatively cheap as compared to now. I don't think that could ever be possible for me to do again. My health is also contributing to that.....My health condition does give me problems.....I can't be engaged in any work at all.....We struggle a lot with the provision of basic needs. I sometimes ask for food from my sister. Occasionally we get rent from the room that we have rented .... (Lelentle, Male aged 50)"

Poverty coupled with HIV/AIDS are no doubt the major contributing factors to the problems and difficulties common amongst PPLWHA and hence they are pushed to living in housing characterised with poor conditions which ultimately pose a negative impact on their already compromised health. Interconnected to the poverty experienced by PPLWHA, there are other structures that tend to have influence in such favourable circumstances such as the lack of a comprehensive social security net designed to cushion people against declining income in the country.

Although HIV/AIDS and poverty are two structures that have been identified as real phenomena that are a challenge in the lives of PPLWHA, based on the critical realist theory, in any 'real' situation there is usually a complex combination of relationships that needs to be unpacked. Borrowing from Lawson (2006:45) reality is not merely observable but comprises several domains of which some are unobservable events (the actual) and others observable experiences (empirical). Therefore, other underlying structures and mechanisms interconnected with HIV/AIDS and poverty that contribute immensely and put more pressure on housing problems of PPLWHA including social, economic and political structures and mechanisms need to be unpacked. The next section will present the problems that were highlighted by PPLWHA, both observable and unobservable in their housing and they will be assessed to evaluate their contribution on the health of the PPLWHA and is based on research question three which seeks to outline the possible social, political, economic and cultural agencies, mechanisms and structures that may be contributing to the housing problems and constraints faced by PPLWHA. The housing problems faced by PPLWHA will be discussed under the following three broad headings including:

1. Lack of affordable sanitary housing for PPLWHA;
2. Vulnerability of PPLWHA to security of housing and land tenure; and
3. Lack of housing finance for the low income.

Using the critical realism theory, these three formulate the 'actual domain' of reality as they relate to activation of events generated by real underlying mechanisms or structures, which tends to have influence in favourable circumstances. As Fitzpatrick (2005) observed realist explanation of actual social events and phenomena are not 'mono causal' and deterministic but are rather 'complex' with loops linking multiple causal mechanisms, 'emergent' because from this complexity of new properties may emerge more new properties which may not be inferred from individual components, 'non-linear' because small changes in these complex relationships can bring about sudden and dramatic outcomes.

5.3.3 Lack of Affordable Sanitary Housing for PPLWHA

The mission of the Botswana government through the Department of Housing is "to provide safe and sanitary[55] housing for all by the year 2016" (Government of Botswana, 2000). This national mission is important and relevant, particularly that in the context of HIV/AIDS good housing warrants a more focused attention as a structural factor which has the potential to improve the health of the PPLWHA (Aidala and Sumartojo, 2007).

Although the mission of the Department of Housing in Botswana seem to be in support of good housing, the support is largely theoretical and not satisfactorily implemented because as much as the policy supports good housing on paper, the reverse seems correct because in practice poor housing is a major problem in Gaborone for most poor people including those who are already in compromised health situations such as PPLWHA. Botswana in general and Gaborone specifically has a high demand for low-income housing and an unmet low income housing demand which has been reflected by various sources. The two major housing providers in Gaborone: BHC which rents and sells houses of various sizes to all people and low cost houses especially to low income people; and SHHA, which is responsible for subsidised land allocation to the low income people have explicitly reflected this unmet housing demand and have confirmed it through the long waiting lists they hold.

[55] Sanitary housing means more than just a roof over the head, it also includes the following characteristics: privacy, adequate space and security, structural stability, dwelling durability with proper light and ventilation and an adequate infrastructure for sanitation and waste management (Girardet, 1996).

The Senior Estate Manager (BHC) said:

> "...the housing demand is far much more than the supply. .... However there are other stakeholders in the market that are actually taking over from where we stopped, like the SHHA programme."

However, SHHA Housing officer raised a concern which confirmed that the SHHA programme is overwhelmed with housing shortage:

> "In Gaborone.....since 1982 to date we have allocated 1 256 (one thousand two hundred and fifty six) plots from a waiting list of about 20 000 applications. We have not made any allocations since 2004 because there are no available plots for allocations in Gaborone. (Principal Housing Officer, SHHA)."

The high and unmet demand for low income housing can be attributed to the failure of the public and private organisations responsible for housing supply coupled with the deficiencies in the housing and land policies to satisfy the housing needs for low income people in Gaborone. Consequently this has eventually put pressure on the providers of low income housing in general and SHHA in particular and led to a steady escalation of a great variety of other ways that the poor people use to access housing.

5.3.3.1 Access problems to BHC rented houses by PPLWHA

From the perspectives of PPLWHA there is an acute shortage of housing options that are suited to their current needs and means in the housing market. They indicated that although decent accommodation is available in the formal housing market, it is unaffordable and therefore inaccessible to them. They raised three factors that hinder their access to decent sanitary housing in the formal rental market including: high rental cost; discriminatory eligibility criteria; lack of priority on allocation criteria to vulnerable people including PPLWHA, particularly on the formal housing market.

a. High rental cost

Housing affordability and the high rental cost was highlighted by most of the PPLWHA as integral to their housing problems, particularly the cost of BHC houses which is the main formal provider of rental housing in Botswana. BHC has been given the mandate to build houses to suit the various income groups in Botswana including the low, medium and high cost houses by the Botswana government. However, BHC houses are of high quality and therefore highly priced and beyond the affordability of the poor

(Datta, 1996; Kerr and Kwele, 2000). PPLWHA mentioned that it is difficult for them to afford even the cheapest of all BHC houses. One PPLWHA had this to say about BHC rental costs, which was a general view shared by other PPLWHA who lived in rented housing:

> "...There are companies like the Botswana Housing Corporation who build houses for rent but their rentals are very high and unaffordable to us the low income groups even if the house is said to be a low cost house.....What is intended for low income people in the formal market is not affordable at all; it is mainly occupied by the middle income people (Leungo, aged 33)."

The Senior Estate Manager (BHC) confirmed this by highlighting that the current minimum rental price of a BHC's low cost house in Gaborone is an average of 1 200 Pula per calendar month. Furthermore, since the BHC low cost houses are relatively high quality houses, they are priced beyond the affordability of the low income people. The rental price for BHC low cost houses is therefore more than the gross income of most of the PPLWHA in this study (see Table 5.6). Consequently they end up in occupation by people beyond the low income threshold including the middle and high income people. The good quality housing provided by BHC can be argued to have attracted people who have the financial capability to pay and consequently BHC low cost houses are mainly rented by the above median income group. Politicians have also commented on the affordability of BHC houses, criticising them for leaving out the people with low income. The then opposition leader commented:

> "BHC has deviated from its core responsibility of providing housing for the landless...BHC had turned itself into an estate agent and sells houses at prohibitive prices....BHC should build houses so that those who want to rent, will rent, but those who want to buy are free to do so. BHC is in competition, they sell at inflated market prices. Their policy disadvantages the poor who want to rent BHC houses." (Mmegi Wa Dikgang Newspaper, 16 May 2006)

However, The Senior Estate Manager (BHC) highlighted that their houses are for people with a regular income from a formal employment business saying:

> ".....As the corporation our target consumers are the low to middle income earners. We categorise them by their regular income. They are the working class obviously, so they will provide us with their monthly pay slips to see how much they earn on a monthly basis. On the basis of that we can safely place them within a certain category. ....If they are not working, one needs to have a regular income. Even if one is not working but yet have a proof of that they can actually afford the rental, then they are eligible..... The demand is on the lower income bracket..... I wouldn't say we are meeting the demand, the demand is far much more than the supply. For a number of reasons; you will find that most of our prospective tenants are in the industrial class; where you find that not everybody can

qualify for a loan anyway, either from a bank or from their employer but they still need accommodation"

The requirements for potential BHC tenancy outlined by the Senior Estate Manager indicate that although BHC low cost houses are intended especially for the low income people, in practice they are far beyond the reach of PPLWHA.

b. Eligibility criteria for house allocation

BHC's eligibility criteria for access to rented houses require that the potential tenants have a formal Employment and an income in order to be qualified for access to BHC housing stock. Eligibility criteria for a BHC house appear restricted only to salaried employees and self employed people in recognised businesses. In this respect, the high rental prices coupled with the BHC eligibility requirements discriminate against the PPLWHA from renting BHC houses. This is because most PPLWHA in this study were either in informal or part-time employment and commonly employers in the informal sector don't give employees monthly payslips hence PPLWHA will not meet the eligibility criteria hence they will be excluded from access to the BHC houses. This practice has attracted criticism of BHC for subsidising the middle income people to live in good quality accommodation while the poor are left to live in poor housing (Kerr and Kwele, 2000)

c. Allocation criteria

It is important to note that BHC doesn't consider any particular group of people as a priority group for housing allocation; their housing is allocated on the first come first served basis through the waiting list. However, the waiting list is inevitably long and due to the high demand for the low cost houses, moving up the list is very slow. Although most PPLWHA in this study highlighted that they lack the financial capacity to access BHC houses, for those PPLWHA who have the financial ability, priority access to BHC houses will similarly constrain their access to the BHC houses at the time of need because they have to compete for the available housing from BHC waiting list at the similar level with the general population in Gaborone because of the lack of recognition of 'priority' for the people in desperate housing need.

Since BHC is unable to meet the demand for the low income housing, the bulk of the responsibility of housing the low income has been shifted onto SHHA and the informal housing sectors both of which are evidently overwhelmed with the demand and this will be discussed in the next section.

5.3.3.2 Access to SHHA plots by PPLWHA

It is important to note that SHHA does not rent houses but allocates residential land and housing finance to the beneficiaries for the purchase of building materials and for the payment of labour costs. However, access to affordable residential land for home ownership in urban areas has been highlighted as a problem to most of PPLWHA in this study. On the whole and parallel to the thrust of the Botswana housing policy, PPLWHA expressed their desire to be homeowners particularly because home ownership provides them with a lifetime security; and eventually an investment in a form of inheritance to leave behind for their children. However, PPLWHA indicated that there are several factors that are prohibitive for them to partake in urban land programmes intended to assist poor people with home ownership including limited access to land, unaffordable land prices and land administration related issues, all discussed below in turn.

a. Access to residential land

All forms of housing consume land and therefore land is an inevitable and integral component of housing provision. Generally there is an acute shortage of affordable land in Gaborone. The high demand and low supply of urban land and housing on the formal housing market has been highlighted as one of the key constraints to home ownership for the low income people. The SHHA programme which is the sole provider for low income housing has a high demand and low supply of residential land for the general populace of low income people in Gaborone as was highlighted by both the PPLWHA and the policy makers.

> "The demand for SHHA has always been high. There is a very big demand although I don't have all the figures now but in Gaborone we were once informed that there were about twenty five thousand (25 000) applicants on the waiting list, for residential plots alone. For a place like Gaborone with a population of just over two hundred thousand people (200 000) that number of applicants is quite significant in terms of demand..... The supply was not coping with the demand. I don't have the latest figures really but from my recollection the plots that were being offered were not really coping." (POLICY3)

This high demand for residential plots in SHHA areas can be attributed to the following two factors.

Firstly, SHHA is the only formal programme that is responsible for allocation of residential plots to all the low income people in urban areas and it has been proven to be inadequate as reported in the narrative above. Secondly, the introduction of the Accelerated Land Servicing Programme (ALSP), which the Botswana government introduced in an attempt to facilitate provision of serviced residential plots to the low income individuals in urban areas. This has raised the plot standards and quality hence making them attractive to the people outside the target of low income bracket. Furthermore, these improved services also raised the plot prices and consequently made them unaffordable to many low income people and attractive to the middle and high income people with the financial resources who therefore bought the plots from the low income people. Although the government sell the serviced plots at subsidised prices only to the qualifying low income people, it has been observed that the middle and high income groups benefit more from these subsidies meant for the low income people through the processes of 'land transfers' and 'land fronting[56]', consequently buying out the low income people from their deserving residential plots. These two issues are rife in the low income housing market in Botswana and have been criticised by Kerr and Kwele, (2000) who argues that land transfers and fronting not only squeeze out the low income people from serviced residential neighbourhoods into poor neighbourhoods but it also helps the middle and high income people to penetrate the low income housing neighbourhood hence gentrification of the low income housing areas.

On the other hand, Satterthwaite (2009) has observed that low income people in general are prone to market pressures particularly when their residential areas have been upgraded and serviced. The upgraded land with good infrastructure brings multiple benefits as well as downside to the low income people. For instance, upgraded residential land provides access to improved sanitation and other essential services such as water and electricity. However provision of such improvements also carry some

[56]'Land fronting' here refers to an illegal land transaction whereby a qualifying person who applies for a plot allocation has pre-arranged to sell it to someone else with more resources to develop it, but who might not have been eligible to apply on their own behalf due to several reasons including that they are already land owners or are non citizens.

hidden costs including the liability to pay for provision and maintenance of such utilities including water and electricity and in some cases local taxes and service levy which low-income households find it difficult to afford.

b. Cost of residential land

PPLWHA indicated that the process involved in using the SHHA programme coupled with its requirements from the potential beneficiaries is costly and complicated.

> "Land acquisition is difficult in the formal market because the process is so long and can be costly, particularly in the urban areas and this includes both buying and allocation (Saone, aged 35)."

The burdensome and costly process of using SHHA programme can be discouraging and may intimidate PPLWHA's participation in formal housing programmes as reflected in the narrative, particularly for PPLWHA who already show some signs of apathy as they feel intimidated by their poverty as well as their unemployment status. This was summarised by one PPLWHA who said:

> "We get information about the housing programmes like SHHA; however the challenge is getting to make use of the programme. The process is difficult for us the low income people, there are so many things that are required from the potential beneficiary: the house plans that meet specific building standards; the financial estimates for the entire development of that specific house plan and these involve a lot of costs including expenses for making several trips to the SHHA offices. These hidden costs and the building requirements make it difficult for people to access the available programme.....Besides that they are also considering the applicant's monthly income of which most of the people here cannot afford" (Kago, aged 40).

c. Eligibility criteria to land allocation

Similar to BHC houses, the eligibility criteria for allocation of SHHA plots has some access limitations to PPLWHA: for instance, the requirements from SHHA beneficiaries which include proof of income, and evidence of regular formal employment may be criticised to be discouraging to unemployed and self employed PPLWHA with other forms of income sources from participation in the SHHA programme. In observing that most PPLWHA in this study were either in informal employment or were unemployed, the plot allocation eligibility criteria used exclude them from access to the SHHA plot and therefore leave them without alternatives for housing within the formal housing market.

Furthermore, applicants for the SHHA programme are administratively required to submit plans for their proposed permanent houses to SHHA office for approval in accordance with the Building Control Regulations. Given that most SHHA beneficiaries are unfamiliar with architectural, engineering and site plans, the SHHA personnel also give them advice on building materials, house sizes, site plans and housing quality. PPLWHA however found the process as cumbersome and expensive in terms of time invested in the process as well as the monetary value of the requirements. Most old SHHA plots are still under the Certificate of Rights (COR) tenure although a change to the Fixed Period State Grant (FPSG) was approved following the review of the SHHA programme in 1992 (Ministry of Finance and Development Planning, 2003: 334). This is because the process of changing tenure is burdensome and expensive in terms of time and monetary value especially to the poor and the low income people. In order to convert a COR title to FPSG, plot holders must satisfy such conditions as:

- Commission a cadastral survey costing approximately P2,000;
- Arrange a water connection, which costs about P600 (equivalent to one month's salary for most low income people);
- Register the new title at the Deeds Registry Office (there is no registration fee if the value of the plot is below P20,000);
- Pay the title conversion fee at the Deeds Registry Office - The first stage in the conversion process is for the COR owner to apply to the city council for conversion. Once a survey diagram has been approved by the Department of Surveys and Mapping, it is followed by the registration of title at the Deeds Registry Office.

The title conversion process is fairly straightforward, however, for the poor the associated costs and process of land surveying and title registration are prohibitive (GeoSolutions, 2007; GoB, 2003; GoB, 1992).

One of PPLWHA in this study, who bought a SHHA plot and needed a mortgage to develop the plot, had to go through a lengthy and costly process of title acquisition, title transfer from COR to FPSG, ownership transfer before she could apply for the mortgage as narrated here below:

> "The process was long and hectic; the process of title transfer was delayed because the plot had to satisfy some building requirements in order to be given the title deed to be transferred to the new buyer....There was a problem of missing Certificate of Rights (issued upon allocation of a SHHA plot). We were advised to re-apply for the new certificate; which was another process as we had to follow all processes of land allocation...Thereafter there was a need for an 'approved' house plan for the house on the plot for issuance of the certificate. So we had to get someone to design the plan of the house because originally the house on the plot was developed without a plan and get the approval from the building control department. I also had to transfer the Certificate of Rights into the Fixed Period State Grant because I needed a mortgage and COR cannot be used to secure a mortgage (Saone, aged 35)"

The problems of access to the formal housing through both BHC and SHHA have resulted in most of the low income people in general and PPLWHA in particular, to be limited to the informal housing which is relatively cheap in price but inevitably poorly constructed, cramped and lacking in amenities as discussed in section 5.1. This informal housing market is available to all the low income people in Gaborone within the highly contested but formal SHHA areas which is the only formal housing programme targeted at the general poor and low income population.

Living in this unregulated informal housing market characterised by poor housing impact negatively on their health as discussed in the next section.

5.3.4 The problem of living in unsanitary housing on PPLWHA

Sanitary housing is both a key environmental influence upon the health as well as a key health resource generally to all people but especially for PPLWHA whose health is already vulnerable, particularly those who are cared for at home since they spend a large proportion of their time within the home. One PPLWHA highlighted their need for safe and sanitary housing by saying:

> "...When a person is sick, housing becomes a crucial need, the patient needs a clean, spacious, private and sanitary space for themselves and the people taking care of them.....Most low income people live in crowded multi-purpose rooms with their families and several other households within the same crowded plots in the urban areas....Hygiene and environmental quality are usually compromised in such conditions"(Saone, aged 35).

Similarly, the key housing role players interviewed in this study including the policy makers, the housing service providers and the HIV/AIDS support services unanimously acknowledged the importance of sanitary housing to health of PPLWHA and indicated that they are aware of the insanitary housing conditions as well as its resulting consequences

for the health of PPLWHA. The Housing Officer in the Department of Housing commented that:

> "...We [Department of Housing] believe that if there is adequate housing in the country; adequate in sanitation, water, and electricity... then our contribution to control of HIV/AIDS will be realised. In the event that we have a household that has an HIV positive person and they are living in squalid conditions, obviously that person will not get well and there are chances that the contagious diseases related to HIV such as tuberculosis will spread within the household"(Housing Officer, Department of Housing)

Although PPLWHA are not concentrated on their own in a single geographical area, they live amongst other poor people who are not randomly distributed throughout the city but concentrated in the most devastated neighbourhoods, characterized by limited economic opportunities, unemployment, poor environmental quality, inadequate and unstable living arrangements which has the potential to compromise their already vulnerable health and socio-economic position.

The housing conditions within the informal housing market that PPLWHA live in are commonly characterised by the problems of overcrowding and congestion which is evident in shared plots, shared rooms and shared toilet facilities, all discussed below in turn to evaluate how they impact on the lives of PPLWHA.

a. Overcrowding and congestion

> "Overcrowding is associated with low space per person, high occupancy rates, cohabitation by different families and a high number of single units in one plot" (UN-Habitat, 2003:11).

Overcrowding has been a problem in low income neighbourhoods in Botswana as reported by GoB (2000): in 1989 there was an average of 3.34 households within SHHA plots, compared to the desired national average of 1.49 households per plot. Over twenty years later overcrowding is still a problem among the low-income people as was evidenced by high densities in most plots used by PPLWHA. Most of them complained about congestion caused by 'too many people' and 'too many housing structures' in their housing environments. A high level of sharing was evidenced on residential plots shared among several households; single room spaces shared by several people; pit latrines shared among several people. Consequently, this high level of sharing posed a negative impact on the health of PPLWHA as well as the people who share the facilities and environments with them.

b. Sharing of plots by several households

Plots with a high occupancy rate are a common phenomenon in the low income housing markets where plots are usually used communally by several households. It appears appropriate to emphasise at this point that the informal rental housing in Gaborone is nested within the formal ownership housing market and most of it is provided with a particular goal of income generation. Therefore, the low income landlords resort to using all the available space at their possession within a single plot for this purpose hence the high rate of sharing of plots in low income areas.

In an attempt to control overcrowding within plots in Botswana, there is a Development Control Code[57] which is supposedly designed to regulate the residential plots to have a maximum of two structures, one being the main building while the other is a servant's quarters or an out building (Gwebu, 2003:418). However, because the informal rooms constructed exclusively for informal renting are provided within the formal market, the plotholders abide by the stipulated Development Control Code for the construction of the formal main house, and fail to abide by it on the construction of the informal rental rooms. This was observed on the various rooms on the informal housing market in Gaborone and further confirmed by Leduka (2000) who wrote... "There is usually no restriction on the construction of rooms for rent in the informal housing sector"

Interestingly, the national housing department highlighted knowledge of both the widespread housing related informalities within SHHA areas including among others informal renting, informal building structures as well as the high plot occupancy rate. However the government is constrained from taking action largely because the informal sector has filled the gap between the housing demand for the poor and the housing supply by the government. Therefore it is not easy for the Government to interfere in informal rental market as it realises that the market caters for the substantial part of the housing for the poor people which it failed to satisfy.

[57] The statutory Development Control Code is intended to regulate building construction in SHHA areas ensuring that there is a measure of safety, health, amenity access and hygiene as well as ensuring that the land will maintain its value. However, most structures in the old SHHA areas in Gaborone have not adhered to these building control and regulation measures (Gwebu, 2003)

The seven PPLWHA who lived in rented rooms in this study indicated that there is an average of six households and more than ten people within their shared plots; which translates to a high population density within shared plots. This was not only a problem to the tenants; the individual informal landlords in this study also shared a similar concern over crowding and congestion on their plots. There are two outstanding cases that highlighted an overwhelming amount of crowding on their plots as highlighted in these narratives. The first case is Loago, an unemployed 46 year old single mother who lives with her six children (three over the age of twenty and three teenagers), five grand children and a guardian to four of her late sister's children.

> "There are three single room structures and four shacks in the plot. We use one room and one shack and the other two rooms and two shacks are rented out. The remaining shack is used as a cooking space when the weather conditions are not good. .....We are so many and I suppose we are more than thirty in the plot because there are also children in the rented rooms. There is also an informal alcohol outlet (commonly known as shebeen[58]) in the plot" (Loago, aged 46).

The other exceptional case is that of Seabe, a single mother of six who is unemployed and an informal landlord. There are three housing structures in her plot, one for family occupation and two for informal renting. Although the number of houses on the plot is relatively reasonable, the number of people living within the three houses is overwhelming as reflected in the narrative:

> "I rent spaces to individuals within shared rooms on a weekly basis to the immigrants.....One person stays for a maximum of a fortnight but other people extend their stay for a month. The shared space is charged 40 Pula fortnightly per person or 50 Pula per month per person. I accommodate a maximum of thirteen people per room in summer mainly because it is hot and can be uncomfortable to accommodate many people. However, in winter as it gets cold at night and feels warm to be crowded, a room can take up to 25 people (Seabe, aged 45)

The two cases are a reflection of the severity of overcrowding in some plots. For example, in the narrative above, Loago could not give a precise number of people in the shared plot she lived in which by implication emphasised that some of the plots are dramatically overwhelmed with the population density consequently compromising the environmental quality.

[58] A shebeen is a drinking establishment where liquor is sold without a licence and commonly in a residential plot. Most shebeens have no regular opening hours therefore; they may operate throughout the day and into the early hours of the next day. This practice is sometimes done concurrently with informal landlordism as in the case of Loago, aged 46. In this case, the alcohol customers add on to the already overcrowding problem experienced by the people renting rooms in the plot.

On the other hand, some PPLWHA indicated that although they are not overcrowded in their own room spaces however, sharing the residential plot with several other people have placed them in overcrowded situations. In addition, the high plot occupancy rate is further exacerbated by the additional informal income generating activities that is rife within the SHHA plots, particularly practised by the land owners. The sale of informal alcohol from a shebeen is the common income generating practice in the residential SHHA areas. The shebeen customers therefore add to the already high number of the tenants and increase the average number of people on the plots further increasing the population density of people per plot hence overpowering the size of the plot and other communal facilities, including the shared pit latrines that are used for toilet facilities which will be discussed later in this section.

c. Overcrowding within a shared room

There is no standard measure of overcrowding within the bedroom in Botswana; however there are many international definitions used elsewhere. The definition for overcrowding used in this study is derived from the UN-Habitat (2003:12) definition, which states a maximum of two people per habitable room. A dwelling is overcrowded when there are a total of more than two people sharing a room. Most of PPLWHA shared the bedroom with several other people hence the high occupancy rate reflected in Table 5.7.

Table 5.7: Population density per bedroom		
Number of People sharing room including PPLWA	**Description of room occupants**	**Frequency**
1	Single adult	8
2	A couple or single adult with one child	6
3	Couple with a child or single adult with two children	5
4+	Adults and children	7
Total		**26**

Source: Authors' compilation

In this study, there was an average of two adults and one child sharing a room. The number of people sharing the room with PPLWHA ranged from one to nine. HIV/AIDS could contribute to the problem for these two reasons:

i. HIV/AIDS drains people economically hence makes it difficult for them to afford sanitary houses with enough space suitable for the total number of household members as extensively discussed in the preceding sections. The use of multipurpose single rooms in this study was common as PPLWHA not only shared the room with several other people but also used the rooms for all the activities including sleeping, bathing, cooking and resting.

ii. HIV/AIDS increases the household size for some poor families who lost family members to the epidemic and are as a result now caring for HIV/AIDS orphans in limited housing space and minimal resources available and affordable to them. Some PPLWHA indicated that they are fostering children of their late relatives in spite of their poverty and lack of sanitary and adequate housing. Kaone aged 37, a single mother of an epileptic daughter and guardian to two of her late sister's sons had this to say:

> "I share the bedroom with my daughter and my late sister's two sons and there is no privacy at all. If I had the means, I would build myself a separate room on the plot and leave the one I am using for the boys, but I don't have the finance to do that (Kaone. Aged 37)"

The level of crowding has a direct bearing not only on the housing quality but also on the health of the occupants. High levels of crowding create poor housing quality consequently compromising the housing quality. A combination of inadequate, unsanitary and unsafe housing can affect the physical and mental health as well as jeopardise the privacy and security of people. Congested space can be a vehicle for transmitting contagious opportunistic diseases associated with HIV/AIDS such as tuberculosis[59]. According to Marsh et al (1999), overcrowding has the potential to increase vulnerability to airborne infections including some respiratory infections such as tuberculosis as well as enteric[60] diseases such as diarrhoea, both of which are often more frequent in overcrowded houses. By implication, in the case that PPLWHA develop any of the aforementioned opportunistic infections, their risk of transmission to the rest of the people sharing the room will be heightened. The contraction and spread of such diseases is further facilitated by the widespread lack of personal and environmental hygiene, which is inevitable in overcrowded room spaces. Furthermore, it is important to note that other factors such as poverty and poor nutrition faced by PPLWHA act as catalysts to the problem.

Furthermore, sharing space undermines the privacy needs of PPLWHA as was evident in this study through all the people sharing the space complaining about the lack of privacy in their shared space. Although all the respondents were not yet AIDS patients, they highlighted that sharing compromises their privacy from the level of sharing the plot to sharing the room. They complained that when they fall sick, their health status is likely to be known by all the people sharing the plot because the living arrangement in shared plots compromises private living and this could contribute to PPLWHA being stigmatised by the people sharing the plot.

Furthermore, some PPLWHA indicated that living in overcrowded rooms obstruct them to negotiate space for their personal activities. Lame, a 35 year old single mother who shared the bedroom with her 14 year old son said:

> "The whole issue of sharing the house is a challenge to me because I need my personal space for me and my son.....Sharing a bedroom with my son is another challenge mainly

[59] Worldwide, tuberculosis (TB) is the most common opportunistic infection (OI) among HIV-positive patients (Crampin AC et al, 2010).

[60] Diseases classified as enteric enter through the mouth and intestinal tract and are usually spread by contaminated food, water, or contact with contaminated vomit or faeces.

> because of our gender difference. There isn't much I can do about it but I feel the pressure and also see that he is feeling the pressure as well, he is a teenager now. Sharing a room with my son gets into my personal life as a young woman; I can't invite my partner nor visit him for a sleepover because I have to be exemplary to my son..... (Lame, aged 35).

The narrative upholds Krieger et al (2002)'s point when they argue that overcrowding can contribute in the same way to the mental and physical health of PPLWHA consequently exacerbating the stress already caused by ill-health and poverty on them.

Other problems associated with overcrowding highlighted by PPLWHA include the emotional stress associated with living in a poor, noisy, stressful and an unpleasant setting; these unhealthy habits that contribute to vulnerability to HIV infection (particularly used as coping strategies)

For instance, some of PPLWHA with teenage children in this study have highlighted that their teenage children resort to sleep over or even move in with their boyfriends to avoid and reduce the overcrowding by saying:

> "It is a problem, they (the teenage daughters) don't like it here and they are always away at their boyfriends' houses. I used to be uncomfortable with it but I have since given up. There is no use on feeling stressed about it because at least they feel safe and live a better life with the boyfriends than here at home with all these many people. My children used to bother me about this place and they would ask me as to when we will move out, but I always told them that I cannot afford to move from here" (Loago, aged 46)

Several factors are reflected here: poor people in desperate housing situation adopt the desperate measures to cope with their problems although they are aware of the long term consequences hence putting their health at risk. Drimmie (2002) concurs with Braubach and Savelsberg (2009) in observing that the lack of stable housing directly impacts on the ability of people living in poverty to reduce health risks; particularly the risky behaviours that make them susceptible to the infection and spread of HIV/AIDS. As evident here, PPLWHA's teenage girls are pushed by the housing situation in their families into vulnerable situations conducive to contract HIV/AIDS through being dependent on their male partners for shelter needs.

With the overcrowding within plots and rooms, problems particularly related to sanitation, environmental health, safety and security are inevitable. Lack of proper sanitation is responsible for causing and spreading diseases. When the provision of sanitation services is inadequate, people become susceptible to disease. In this study, shared pit latrines used

for toilet facilities are one of the sanitation facilities that were highlighted by most of the PPLWHA in the study and will be discussed below.

d. The high usage of shared pit latrines

Pit latrines are common in most of the low income housing neighbourhoods in Gaborone, particularly those constructed in the 70's and 80's during the introduction of SHHA. A high usage of the shared pit latrine used for toilet facilities in the study was common: 21 out of 26 PPLWHA indicated that they used shared pit latrines for toilet facilities while only five used modern water system toilets. In the view of the reported congestion and overcrowding within the plots in this sample, the communal pit latrines are inadequate for use by the general populace on the overcrowded plots and a potential health hazard to all tenants, particularly those PPLWHA whose health is already compromised. Three PPLWHA indicated that there are shebeens in their place of residence; increasing the number of people on the plot consequently overusing the pit latrine. The reported overuse of the pit latrines, which is further worsened by lack of sanitary cleaning and maintenance as well as poor construction and design therefore becomes a potential health hazard (Gwebu, 2003; Chaggu, 2004). Due to their heavy usage, the pit latrines fill up rapidly and some even fill to the extent of overflowing if not drained regularly as highlighted in this narrative, which reflects the complaint raised by other PPLWHA in overcrowded plots.

> "..... We all use the pit latrine and it is always overflowing because it is overused; it needs to be cleaned everyday and drained on a regular basis. If I could miss the cleaning for a day or two due to circumstances, the situation of the toilet becomes so appalling and a health hazard to my children (Seabe, 45)"

Neglecting pit latrine emptying requirements can have serious health and environment consequences; for example, Parkinson, (2008) quoted by Thye, et al (2009) reported that substandard pit emptying services in Freetown, Sierra Leone was reported to have partly caused diarrhoeal disease and cholera outbreaks, especially in poor neighbourhoods. If the users continue to use the pit latrine when it is full, the excreta overflows therefore increasing the risk of contamination consequently reducing the overall benefits of improved sanitation on the health of PPLWHA substantially. Overflowing pit latrines have the increased potential of attracting disease bearing insect vectors such as flies and cockroaches, which are commonly known as frequent transmitters of germs associated with diseases such as cholera and various types of diarrhoea as well as other food borne diseases. The potential hazard produced by the overused pit latrines coupled with the

insanitary housing conditions that PPLWHA have reported are a hazard which further compromise their already vulnerable health condition.

When adequately maintained, pit latrines have a lifespan of 12 – 15 years; thereafter they start to discharge serious air pollution (Gwebu 2003). The stench from the pit latrines pollutes the air around the entire neighbourhood affecting all the PPLWHA within the surrounding as well as the people who live on the plot.

Some of PPLWHA have highlighted that although they are aware and uncomfortable in the overcrowded and poor housing conditions, they feel constrained to respond to the situation because they lack the financial capacity to respond to the situation. This was particularly raised by PPLWHA who are either living for free in a family home and those who live in relatively cheap rooms in which they pay very low rental price.

The lack of regulation of the informal housing coupled with the lack of welfare structure that assists PPLWHA with sanitary housing provision is a stumbling block in the housing for the vulnerable people. Consequently they face problem of insecurity of tenure as discussed in the proceeding section.

5.3.5 PPLWHA's security of tenure

One of the problems faced by PPLWHA in their housing was the reduced security of tenure for either the rented accommodation or the allocated undeveloped residential plots. They highlighted that they are vulnerable to lose either (a) the security of housing tenure or (b) undeveloped residential plots, which are discussed below in turn.

a. Vulnerability to lose housing tenure security

The PPLWHA particularly complained about their vulnerability to lose the rented accommodation rather than losing the owned homes. Most PPLWHA in informal renting indicated that they occupied their rental rooms informally and without any legal contracts but through consensual agreement with the owner, which by implication puts PPLWHA in a vulnerable position which has the increased potential to lose the rented accommodation at any time without any compensation from the landlords due. Some of the possible reasons that PPLWHA indicated to have the potential to contribute to the loss of their accommodation include:

i. Failure to pay monthly rent

PPLWHA raised a common concern that they are vulnerable to lose their rented accommodation because in the event of loss of income, the family has the potential to fail to pay the monthly rent consequently losing their accommodation.

> "Sometimes I get really worried when I don't get the money to pay the rent in time because the landlord can easily throw me out of his room and get someone who will be ready to pay as per agreed"(Tebogo, aged 35).

As much as the process of getting accommodation in the informal housing market is relatively easy as it depends on 'the ability to pay rent', losing it is equally easy, particularly that there is neither legal agreement nor regulation that protects either the tenant or the landlord. This is parallel to the notion of petty landlordism by Kumar (1996) who contend that 'petty landlords' are found in the informal housing market with the aim to rent part of their housing properties in order to earn an income and letting of rooms may be the only source of regular income. PPLWHA are particularly at an increased risk of losing their housing during the time of illness when they are incapacitated to engage in labour intensive employment activities commonly done by the poor people. The data indicate that most of PPLWHA in this study are engaged in either informal employment with little or no job security, or are involved in income generating activities which are also relatively unsustainable, particularly during the stage of being an AIDS patient unable to engage in labour intensive activities. This has already happened to one PPLWHA who said:

> "I lost my job .....when I was sick and couldn't be at work all the time... I even lost the house that I was renting from BHC because I didn't have the money for rent payment."

The vulnerability to lose tenure due to financial difficulty could contribute to vulnerability to managing HIV/AIDS for PPLWHA. For instance, in an attempt to cope with the rental payment from unreliable and limited income, PPLWHA live with male partners/boyfriends. Consequently this contributes to the dependency of female on male support, particularly for the payment of the rented accommodation. Some PPLWHA indicated that they depend on their boyfriends for financial support particularly for rent payment:

> "..... My boyfriend takes care of all my living expenses because he is employed and I am not.... the room is rented by me although he pays the rent for it .... I don't know what will

> happen the next day with me and my boyfriend so I don't feel secure in the house, the chances of losing it are high" (Laone, aged 37).

At face value, the female dependence on male partners for financial support including rent payment is a common cultural practice in Botswana (a patriarchal society) because men are culturally expected to provide social and economic care and support to their female partners (Maundeni, 2000). However, on critical consideration, the female dependence on men has implications that have the potential to heighten the spread and control of HIV/AIDS. Physicians for Human Rights (2007) have indicated that women's economic dependence on men is the most significant contributor to women's greater vulnerability to HIV. Women's inferior economic position makes them lose control of their financial decisions to their male counterparts particularly those whom they are dependent upon such as their boyfriends. Consequently the lack of control and dependence does not only end in economic support but extends to the sexual relationships which underlie women's lack of autonomy in sexual decision-making.

ii. Sudden rent increase and poor relations with landlord

The PPLWHA indicated uncertainty of the security of tenure on their housing due to unregulated and irregular rent increases on the already high rent prices they pay for the poorly maintained housing.

> "If the landlord decides to increase the rent, I will have to leave the room because I won't afford to pay any more than I do pay now. For instance, the landlord has currently increased rent without even consulting with us; he just gave us a month's notice.....I am also vocal and express my dissatisfactions with the landlord especially during the tenant meetings and this might make me lose the room because the other tenants hardly complain to the landlord because they are scared of losing their rooms" (Batho, aged 26).

In the absence of legislation relating to various landlord and tenant matters including protection of tenancies as well as control of rent, tenants become vulnerable and subject to exploitation by some landlords. The high rent-to-income ratio was evident among PPLWHA in rented housing. This was a concern even in this study as outlined in the narratives by some renters:

> "Personally I have other expenses to take care of, such as the school fees, school meals and transportation charges for my son, so if I have to pay a high rental amount, then the other equally important needs are going to suffer....."(Leungo, aged 33)

iii. Failure to abide by landlord's ground rules

In the era of HIV/AIDS, research has indicated that female-headed households bear most of the burden of care. However, some PPLWHA have highlighted that despite that Batswana are a society where extended family is valued and the support of extended family is fundamental, some landlords have set requirements for renting their housing that exclude people with dependants as outlined below:

> "....there are ground rules that the landlord has set for the tenants to follow: only single people without children or dependants are allowed to rent the rooms in the plot..... there is a cleaning rota that we follow; men on the plot are responsible for cleaning the toilet *(pit latrine)* while ladies keep the plot surrounding clean. Those tenants who carry out their duties according to the agreement don't lose their tenancy. I have been renting the same house for over four years and there are two people who lost their tenancy for lack of compliance with the set rules." (Khumo aged 28).

Such landlords may be criticised for being discriminatory especially to women as they are the ones who bear the burden of care especially at this time of HIV/AIDS. As reflected on this study as only three out of twenty six PPLWHA indicated that they are single and without dependants indicating that only a few could qualify to access housing under the outlined restrictions. Furthermore, given that PPLWHA experience times of illness that need home based care from a caregiver (as is common in Botswana society) PPLWHA will then become vulnerable to lose their housing during the time of illness. Although this was a single occurrence, it however highlights that PPLWHA, particularly women, are vulnerable not only to stigma and discrimination, due to their HIV health status, but also due to the burdens that come with HIV/AIDS.

iv. Overcrowding and related problems

Although some of the PPLWHA indicated that they are at the mercy of the landlord to lose their tenancy, for some it is out of 'choice' which is arguably prompted by the environmental conditions unsuitable for the health of PPLWHA such as excessive noise from the neighbours and unsanitary housing conditions.

> "When you are renting, there are always disputes about this and that so I decided to move places. The plot had too many people in it and was a bit noisy for me" (Laone, aged 37)

In a nutshell, as mentioned in the preceding sections, the informal housing market (which is the only one available for PPLWHA in this study) is a sub-market nested within the

formal housing market. Therefore due to its informality, the level of recognition by authorities is minimal and so is the likelihood of governmental response in terms of any irregularities in the informal housing market. This is certainly a major gap in terms of provision of an appropriate framework that protect the tenure security of low income people. The absence of regulation and the lack of enforcement of rent control in the informal housing market have therefore left the tenants at the mercy of the landlords. The oversight of the housing policy on this aspect has given the petty landlords the opportunity to set their own framework which is obviously neither legal nor considerate to the tenant consequently making them vulnerable to tenure insecurity and lack the autonomy and control over their own rented housing. For PPLWHA, life in the informal rental market means that housing costs are high, security of tenure is low and the chances of changing to tenure such as home ownership or formal rental are decidedly small.

b. Vulnerability to lose undeveloped residential plot of land

PPLWHA highlighted that they are not only vulnerable to lose their rented accommodation as discussed in the preceding section, but are also vulnerable to lose their undeveloped residential plots. PPLWHA may lose their undeveloped land through three distinct ways: firstly, by losing it back to the government land allocation authorities as residential land left undeveloped for a particular period of time is repossessed for reallocation; secondly to individuals through informal land sale and thirdly, through dispossession by family members through land grabbing.

i. Loss of plots through repossession back to the government

Land allocation is intended to facilitate economic and social development. Therefore, the land allocated to individuals has to be developed and to be used for the intended purpose within the specific period. People who are allocated land (both state and customary land) in Botswana are legally required by the land regulations to have it developed within a specific period of time failing which the land reverts back to the state for reallocation as was reflected from the interview with the Director of Lands who said:

> ".....state land should be developed within a particular length of time failing which the department will take it back for redistribution to those who can develop it."

Although none of PPLWHA in this study experienced land repossession, they however highlighted their awareness of the land development and repossession policy which applies to all people allocated land without being discriminatory. Land repossession has however attracted criticism from the public who argue that the land repossession policy is not only an 'anti-poor policy' that attack the poor people who have the financial difficulty to develop the land within the specified period but it further undermines the locals' property right as land is a 'right' to all citizens. A personal opinion was posted by a member of the public in the local newspaper expressing concern regarding the land repossession policy:

> ".....Botswana does not have an effective social security system. In response, rural families (and many urban workers) retain their family fields (land) so that if disaster strikes and all else fails, they can go back to the land and grow their own food. Land is the ultimate form of social security. Consequently, this policy is a direct attack both on the only social security that many poorer households possess but also on citizens' property rights, as the owners of these fields see them as their property and birthright" (Mmegi Newspaper, 21st April, 2010).

Land, similarly to housing is a commodity that does not only offer shelter but also offers social security and can be of crucial importance particularly when the traditional means of social security such as local networks based on kinship are eroded and access to institutional social security is absent (Smets, 2006). Therefore repossessing land from PPLWHA strips them of their valuable asset that they could otherwise use as an investment for their current housing need as well as for the future investment to leave behind for their children as inheritance, especially that there is a lack of a comprehensive national social security net to cushion people against both declining incomes and failing kinship ties.

Furthermore and of great importance is to note that possession of a residential plot of land forms the main part of the basic requirements for eligibility for a SHHA loan, therefore repossessing land from the poor people disqualifies the PPLWHA from the only available formal housing finance provider. It also ruins their future chance to use the SHHA programme and ultimately be home owners hence they may be confined to the informal housing market for a long period of time, particularly as they cannot afford to participate in the 'commercial' land market to regain a plot for residential use.

However, in responding to land repossession policy, some PPLWHA indicated that they devise strategies that help them benefit from their allocated land such as subdividing, partially or entirely selling the plot. For instance, one PPLWHA partitioned and exchanged a part of her plot in return for a 'two roomed house' as narrated below:

> "My plot was a big plot therefore, when I realised that I may never afford the building costs, I partitioned it and got into an agreement with someone to develop a two and half roomed house in return for part of my plot.....I didn't have any other place to live with my children so the best thing was to partition rather than sell the entire plot... At that time I needed a better accommodation because I had a new baby and we were crowded in the room, I was also faced with a financial crisis" (Seabe, aged 45).

It is important to note that although HIV/AIDS may have influence on people's inability to develop their land, the data is not specific about the causative powers HIV/AIDS has on the loss of land tenure. The Director of Lands had this to say about the observed causes of loss of land tenure in his Department, particularly people who fail to develop it within the required time:

> "Here we are faced with many sorts of challenges; there are people who have been allocated plots and find it difficult to pay for the plot, however, we cannot say that it is due to the high prevalence of HIV/AIDS because even those that are neither infected nor directly affected may find it difficult to pay due to some other reasons...."

The restrictions on land use generally encourage the development as well as the thriving informal land market which may ultimately encourage land grabbing since the poor lacking income opportunities or a social safety net may resort to distress land sales.

Some PPLWHA who have been allocated land but experience difficulties in developing it within the stipulated time-frame highlighted that they feel constrained and therefore resort to plans of benefiting from the land such as selling their plots of land for financial gain rather than lose it back to the government for redistribution without compensation. The informal land sales have however raised concerns among the people as well as the government as it is believed they take away the land from the poor and vulnerable people and transfer it into the hands of the relatively rich people as discussed in the proceeding section.

ii. Loss of plots through transfer of land rights in the form of informal land sales

Land rights are important as they influence the rights of access, exploitation and transfer of land (Baddock, 1984 quoted by Lawson, 2006).

Botswana Land Law clearly stipulates that land rights in Botswana are not saleable but transferable. However, landholders often find ways around these laws and sell undeveloped land through concealing it as land transfer. Besley (1995) argues that when land transfer rights are supported by the land authorities, it makes them easy to transact and

consequently the desire to trade land coupled with the outside economic opportunities such as offers to buy or rent the land from their owners is generated. Nevertheless, participants in this study regard land sales as a regular, though not always desirable, feature of the land tenure system. For most PPLWHA, land sales appear to be a pressured response to financial difficulty, and not an active engagement with available economic opportunities. They reported that they transfer their undeveloped land rights in a form of land sale for two particular reasons as explained by one of PPLWHA whose narrative upholds that of other PPLWHA in this study: firstly, to avoid losing it back to the state upon the elapse of the time allocated for plot development.

> "People have now devised a strategy that is beneficial to them; most people I know sell the plots they can't afford to develop within the specified time rather than giving them back to the government for free....The reason behind my selling of the plot was that the five years were elapsing before we could develop the plot and we were going to lose it back to the government while we didn't have a habitable structure to live in as a family" (Kabelo, aged 34).

Secondly, land sale boosts their finances especially in times of financial need.

> "Besides, the money earned through the sale of the plot is used in helping the family with other basic needs and caring for the sick person in some incidences" (Kabelo, aged 34).

However, these land sale/transfers are mostly from the poor and vulnerable people to those who have the means to buy and invest in the land and not those who are necessarily in need of residential land for personal residence. This skews distribution of land towards the rich.

Selling their residential plots brings several negative consequences to PPLWHA as they are being dispossessed of their valuable commodity and left landless hence having no land to leave behind as inheritance for their children. Secondly, they are being squeezed out of the good quality and sanitary residential areas into poor sub-serviced land in the urban periphery or perhaps into the informal rented housing which is not particularly suitable for the already compromised health of PPLWHA.

Neo, a single mother aged 40, indicated that she sold her plot due to financial strife and in an attempt to prepare for her children's inheritance as she succumbed to the epidemic. However since she lost her plot through selling, she has never lived in a comfortable place and as she said:

> "I had my own plot but sold it in 1993 when I thought that I am going to die from HIV/AIDS.....So I sold the plot with the intention to invest the money for my children, however, I couldn't manage to invest the money because I lost my job and needed that money for my living expenses."

Although selling land seems as if people dispossess themselves of their assets, as Mathuba (2003) argues, it is important to note that there are underlying factors that contribute to the situation. For instance, in the face of HIV/AIDS, households are likely not to act in accordance with any formulated plan or strategy but react to the immediacy of their current need when no other alternatives exist, which maybe disposing off their assets, (Kamusiime, 2004). During the time of need, decisions are not based on the importance or usefulness of the asset to the household but saving lives is deemed more important than preserving assets. This is evident in that even land, the "most important asset", may not be spared in the quest to cope with illness.

However it is important to note that although PPLWHA who lost their land through land sales have highlighted that HIV/AIDS have somehow contributed to their decision to sell their plots, evidence is not specific that HIV/AIDS is the main cause for the decisions to sell land and loss of security of land tenure.

Although distress land sales and other related response to AIDS-induced financial pressures, appear relatively rare among PPLWHA in this study, anecdotal accounts provided by some interviewees highlight that there are other people who had sold land as a consequence of HIV/AIDS. This is an indication that there is a potential problem of distress land sales related to HIV/AIDS that needs further investigation.

On exploring further to find out as to where PPLWHA who sold and consequently lost their residential plots live, PPLWHA highlighted that they have since moved into either the informal housing market within the SHHA areas characterised by unsanitary housing conditions, or in the periphery of the city in family homes where they are exposed to various housing problems which have the potential to further compromise their health as discussed in the previous section 5.1.

iii. Loss of plots by PPLWHA to family members through land grabbing

There have been speculative reports from some of PPLWHA interviewed on loss of land tenure to relatives, particularly from widows and orphans in Botswana. However, on

contrary, there was little or no evidence of dispossession of land rights as a direct consequence of HIV/AIDS. There was a lack of empirical evidence that provides a link between HIV/AIDS and land tenure insecurity in this study and in the general literature as anecdotal accounts had led to anticipate. In this study, none of PPLWHA highlight that they lost their land tenure to family members because of their HIV/AIDS status but rather HIV/AIDS epidemic together with other social and economic ills and pressures on land rights is responsible for land tenure loss which applies to both PPLWHA and households indirectly affected by HIV/AIDS. Taking into account that there are other pressures that impact on loss of land rights: including, cultural practices such a guardianship and patriarchy; socio-economic factors such as poverty; and political structures such as unequal gender relations between men and women, one can regard HIV/AIDS as placing further stress on fault lines that already exist.

For example, one female PPLWHA indicated that she lost land tenure due to the traditional practice of guardianship which places young orphans and their inheritance in the care of their male relatives:

> ".....After the death of my parents, it was unanimously agreed that my uncle become our guardian and all the property that my parents left for us was supposedly placed in his trust for us. Upon the death of my uncle many years later, all the property including that he was supposed to have put in trust for me and my siblings was inherited by his own children and that left us without anything at all.... the tradition is that the elders know these issues. I have even involved the village elders and we are still to meet with my extended family to come up with a solution that will determine the ownership of the plot"(Kago, aged 40)

The traditional norm of guardianship is practised and recognised in Botswana as a social security net especially where the parents die leaving young children however, the practice of these norms are yet to be tested empirically especially relating its effectiveness related to land property inheritance of property for HIV/AIDS orphans. Besides this individual case, there is little evidence from this study to suggest that HIV/AIDS orphans and women are the victims of land grabbing. However anecdotal reports by PPLWHA provided insights of the presence of such practices within the community. In resolving cases of land grabbing such as the one highlighted above, the tradition in Botswana is that land disputes go initially to the elders, and this ensures that in the first instance, there is an effort to resolve disputes in a manner that is consistent with local norms and with the larger community interest taken to heart. However, the relative informality of the local mechanisms for dealing with land disputes is also a potential weakness, especially in an era of changing mores and in particular the household-level crises wrought by AIDS. In this

case, the fate of an individual who finds their land rights threatened owing to the economic or social effects of AIDS depends in large measure on the personal disposition of customary leaders therefore, in instances where the customary leaders are unsympathetic to an infected/affected person, for example, because they 'buy in' to the stigma associated with AIDS or do not appreciate the economic predicament faced by affected parties, that person is far less likely to receive support in defending their rights.

In terms of women losing land rights due to HIV/AIDS, one can argue that there are some of the traditional norms and practices that structure access to land which used to be strongly patriarchal and consequently putting women at a disadvantage in terms of both access to and control over land and resulting in women losing their land tenure. However, there is evidence of shifts occurring in both attitudes and practice, and women gaining stronger rights to land than in the past.

For instance, the Land official interviewed stated that there are no legal barriers to women or PPLWHA's access to own land and suggested that land is distributed equally to Botswana citizens regardless of their gender, health or socio-economic status by saying:

> "As for allocation of the plots....the allocation goes according to the waiting list and....nobody is given special treatment based on medical or social circumstances. Everybody has the right to a piece of land and nobody has the right to a piece of land ahead of others because of a disability or disease" (Director of Lands)

This narrative by implication suggests that there are no legal barriers to women owning land and suggested that the formal land administration system is working to protect women's land rights.

Of note is that in this study no woman reported to have been forced to leave their households upon or as a consequence of the death, separation or divorce from their husbands. Interestingly, one of PPLWHA interviewed who is also a divorcee indicated that she retained her marital home after the divorce.

> "When we divorced he left me in this plot and did not even contest for it. We divorced legally at the magistrate courts, which made things even easier" (Marea. Aged 51)

In this case, rather than losing her rights in marital land, the divorce had made it possible for Marea to register land rights in her own name without any challenges from her ex-husband or his relatives. Thus there is little evidence from this study to suggest that women

are the victims of 'land grabbing' although anecdotal reports from PPLWHA highlighted knowledge of such incidences, more intensive and focused research need to be carried out to confirm such claims.

5.3.6 Access to Housing Finance by PPLWHA

When land rights have been secured, there is a need to acquire housing finance for the development of the dwelling house. Typically, most of the housing structures are financed through home loans and mortgage capital. Most of the mortgage providers and housing finance providers use property as security and allow the borrowers to repay the funds over a maximum period of 20 to 30 years which allows the borrower to spread the payment over time. However, most of PPLWHA indicated that although they possess land rights, they are facing a problem of securing housing finance needed for the development of the residential house. Those who have not yet secured land rights highlighted that they were reluctant to apply for plots as they found it unwise to apply for plots without the necessary finance to develop the plots. Thus the lack of access to housing finance was cited by PPLWHA as among the principal structures that hinder their desire to access sanitary housing and their participation in home ownership hence their living in unsanitary housing conditions. PPLWHA forwarded several factors associated with their lack of access to housing finance discussed below in turn.

a. The administration requirements for housing mortgages are prohibitive to the poor's access to housing finance

Generally, access to financial services for many low income people in Botswana is primarily determined by income levels; consequently the poor people find it difficult to access the banking facilities. PPLWHA highlighted that the low income, self-employed (of the informal sector) and the unemployed are generally excluded from access to financial services through the bank's administrative requirements of the various commercial banks. This was backed by FinMark (2007), who reported that in Botswana, 49% of the population use financial services provided by the formal sector entities and the remaining 51% are not in possession of bank accounts hence are excluded from using the financial services through the commercial banks. On considering that potential housing mortgage applicants need to have a bank account in order to access the housing finance, for the PPLWHA in this study whose low income implies that they are without bank accounts, and

are therefore administratively excluded from access to any kind of conventional housing finance as was reflected by one PPLWHA who said:

> "The financial institutions are not accessible for the low income people. I tried to get a loan from one bank and the requirements disqualified me from their products; they needed a bank statement, payslip and other things which I didn't have." (Kago aged 40)

Nevertheless, there are other PPLWHA in this study who were in possession of bank accounts and are plot-holders who highlighted that they too have difficulty accessing formal housing finance due to several reasons including – being disadvantaged by the land rights attached to their plots, lack of the ability to save and inability to afford collateral required for the housing loan.

As already discussed, the majority of poor people are in possession of plots either within SHHA areas or in the rural villages on tribal land most of which is within the periphery of Gaborone. Both fall outside the requirements needed to qualify for the housing mortgage within the formal housing finance providers due to the land rights attached to them[61]. Despite that theoretically most commercial banks and the Botswana Building Society (BBS) provide housing finance to the qualifying applicants without prejudice, BBS is the only financial institution that is prepared to finance any housing project nationwide regardless of the land rights, the rest of the financial institutions limit their housing loans to urban areas and only to people within qualifying income bracket. Furthermore, the commercial banks have indicated that they are prepared to provide mortgages to the SHHA plot-holders but are prohibited by the COR which gives the user the right to use the land while the state maintains its ownership (Kalabamu, 2005). This is because plots holding COR cannot be offered as a form of collateral to be pledged by the borrower to ensure the fulfilment of obligations in the event of repayment difficulties and loan default because they are owned by the state. As Lawson (2006:67) noted, the value and conditions attached to the land can either attract or prohibit the level of investment on the particular piece of land. For instance, where no barriers exist on the piece of land, investment may flow into the area but where there are barriers; investors are prohibited from accessing the land. Mortgage providers often prefer registered land titles which can be used to recover their investment and any less secure land title may end up hindering the financing process.

[61] Although SHHA plots are now registered under the Fixed Period State Grant (FPSG) tenure which gives the land holder the right to mortgage the land, most old SHHA plot beneficiaries still remains the Certificate of Rights, which gives the user the right to use the land while the state maintains its ownership

Based on that contention and the prohibitive nature of COR, all formal housing finance institutions except for BBS are reluctant to accept the COR plots as collateral for housing loans hence placing the PPLWHA who mainly have COR at a disadvantage.

Although housing finance providers may be criticised for excluding PPLWHA from their services, they are not the sole agencies responsible for the problem. The housing finance system is influenced by the people's ability and capacity to save. The capacity to pay for the home purchase is inevitably linked to one's ability to save. However, for the PPLWHA, the problems of their already low revenue base coupled with the medical related expenses inhibit them from saving consequently the difficulty to partake on the formal housing finance institutions. As Tomlinson (2001) noted:

'Household savings, if there are any, will be used to care for the sick.'

Nevertheless, as UN-Habitat 2003:147 cited by Precht, (2005) have observed, it is not only the formal financial structures that have blocked financial access to the low income people; it is also the low income people themselves who do not use the services provided by banks and mortgage companies assuming that the loan repayments can endanger their family's future. This was evidenced from the responses from PPLWHA in this study, for instance, Lorato indicated that she was using her personal savings to buy building materials while waiting for plot allocation. She commented:

> "I have never thought about getting a building loan from a commercial bank.....They charge high interest rates and I can't afford to re-pay their loans with my small income (Lorato, aged 34)."

Similarly, Peo, who said that she has started building a multi-purpose room in her plot from the allowance that she gets from her volunteering job with the assistance from her boyfriend said:

> "I don't want to get myself into debts ...I want to use my own money to develop without debt. I can't get a loan from a commercial bank because I don't have any regular income and I am unemployed. I might be given a loan but there are also the after effects of getting loans. In case there is a loan that I qualify for, I will find it very difficult to repay because of my low income and end up in legal actions that I don't want to be involved in" (Peo, aged 27).

From the narratives, it can be inferred that PPLWHA are not passive in their circumstances but get active to deduce strategies to deal with and manage their assets as well as they can

in spite of the prohibitive structures that they encounter. But on the other hand, these statements may be an indication that PPLWHA need to be educated and informed more on issues related to housing finance so that they can be able to make informed decisions and maximise the available opportunities.

b. Housing mortgages are unaffordable to PPLWHA

According to FinMark (2007), the poor are generally not qualified for mortgages from private mortgage providers hence excluded from most mortgage schemes available in the formal housing finance market which is solely provided by the conventional banks in Botswana due to the following reasons.

i. Mortgage repayments are unaffordable

Access to housing finance from most of the financial institutions is determined by the income of the potential applicants. Given the very low incomes of the majority of PPLWHA (see Table 5.6), the bulk of which is spent on food, and medical needs it seems impossible for such households to afford conventional housing if only current income is considered for access to housing finance. For instance, Finmark (2007:20) gave an example of the cheapest mortgage available from the conventional banks in Botswana as summarised in Table 5.8:

Table 5.8: Example of Cheapest Mortgage for housing Affordability	
Mortgage Value	P11 500
Net monthly income	P4000.00
Monthly instalment amount	P1 600.00
Interest rate	16%
Loan re-payment term	20 years

Source: Adapted by author from Finmark, 2007

Table 5.8 highlight that PPLWHA are not qualified for the housing loans in the conventional housing finance market. Consequently, they end up devising other ways of accessing housing finance informally such as financing their housing from

personal family savings and borrowing from short-term money lenders although they are generally charged exorbitantly high rates of interest, rather than making long-term housing finance commitment from the conventional financial providers.

ii. Mortgages come as big sums with long-term repayment periods

Housing loans and mortgages are simply not available in the shape and form affordable to the low income households consequently the poor find it difficult to access housing finance. Most housing finance come in a form of relatively large sums of money paid over a maximum long-term period of 20 to 30 years and these are beyond the reach of the low income people as has been reiterated by one of the housing finance providers interviewed who commented:

> "The low income loans are not necessarily within our target group because of their low investment.... a SHHA project is a pretty low investment and at this moment the focus is on the higher investment. But given time in future we may see what to do for those" (Research and Development Analyst, NDB).

In such instances, as Smets (2006) observed, microfinance[62] institutions have been seen as facilitating access of poor households to housing finance; however there is a lack of such facility in Botswana. There are however isolated agencies offering micro finance through Non-Governmental Organinisations such as Habitat for Humanity, which are obviously inadequate given depth of need (This will be discussed in the next chapter which discusses the available interventions provided for housing for PPLWHA through the various organisations).

However some formal lending institutions have recently introduced products such as personal loans, which could potentially attract low-income households. The requirements that the loan-holder has regular employment and the provisions for employment and pay-roll deductions are common and as already discussed, the PPLWHA seldom meet these eligibility criteria.

[62] Microfinance institutions attempt to work with the poor by developing finance schemes whose terms and conditions do not discriminate against those working in the 'informal' sector and those living in 'informal' settlements.

iii. Conditions for the mortgages and related costs are unaffordable for PPLWHA

The conditions of housing loans require a down payment or collateral for security and payment for insurance against defaults. PPLWHA indicated that they lack the security on loans in terms of collateral required by most conventional mortgage providers. This is mainly because the residential land held by the poor does not have the title that is recognised by mortgage providers as collateral, as already discussed, which places them at a considerable economic disadvantage. Furthermore, the hidden cost associated with the mortgages, including interest rate charged and the loan repayments time is generally unaffordable and therefore exclude the poor in general and PPLWHA in particular because long-term loan carry the danger of default and would impose greater risk on PPLWHA who already have financial difficulties due to the double burden of having a low economic revenue base as well as living with HIV/AIDS which is a disease associated with risk in itself.

In relation to the risk of default associated with low income people, one of the mortgage providers interviewed alleged that the poor in general are high risk clients, giving an example of the loan repayment defaults reported in the SHHA loans by saying:

> "Some low income people are prone to loan default although that is not empirically proven .... However, there is a concern that if you burden the low income people with debts, they are likely to default; this is probably the reason why the level of SHHA loan arrears was very high. It was estimated at that time that about two thirds of all the households who took out the SHHA loan were in arrears at any point in time, which is approximately 60 per cent, a really high proportion (Former Housing Officer, Department of Housing)."

c. Building is expensive hence unaffordable to PPLWHA

The cost of residential land, housing and building materials have become increasingly high and thus inaccessible to the poor households and consequently contributing the problem in discussion (Datta and Jones, 2001; Gwebu, 2003). Prices for building materials in Botswana have gone up significantly over the years consequently limiting access to good quality housing by most households. Among the numerous reasons already discussed, the expensive building materials coupled with the government imposed building standards contribute to the problem, especially that there is neither the welfare mechanism nor subsidies to cushion the pressure from expenses for the disadvantaged people.

The issue of building materials is crucial because without the provision of affordable and accessible housing finance, poor households can only afford construction materials that are of lesser quality but affordable to them consequently building sub-standard housing which are not only a health hazard to PPLWHA but to all the users as already discussed in section 5.2.3.

Furthermore, the government has declared all urban centres and major villages in Botswana 'Planning areas' and therefore all developments (including houses) within these must comply with the Development Control Code, Building Control Regulations and the Town and Country Planning Act of 1977 (DCDM Botswana, 2006). This implies that it is no longer possible to develop houses using traditional construction methods and materials due to the insistence of compliance to these legislative instruments. The current costs of infrastructure and associated costs related to set codes, standards and procedure have had an impact on the affordability of housing for the low-income population as was highlighted by some PPLWHA:

> "People should not be forced to develop their plots when they have affordability problems because that also gets some people into unnecessary debts. Currently it is more expensive to develop a house on our plots because the government requires that people should build using specific house plans that are expensive for us the poor....The government also contributes to this by devising requirements that makes it even more difficult for us the poor to develop the plots by introducing the building standards and building plans. Traditional houses are the only houses that we the poor people could develop without getting into debt but the government don't want them and need modern houses developed through house plans and meeting set housing standards.... Poor people should be allowed to build whatever they want in their plots and not be restricted to build according to plans." (Seabe, aged 45)

The set codes, standards and procedure are not only prohibitive in terms of affordability to PPLWHA; they also contribute to the security of tenure as failure to develop the house in a plot result in loss of the plot. Kaone, whose very low monthly income of P350 is inadequate to either qualify her for the housing loan or make a savings contribution for housing construction, indicating vulnerability that she may lose the residential plot she has due to the government's need to comply with the expensive building requirement. She commented:

> "...if I don't get my plot developed the land board authorities will repossess it. At times I think of constructing a traditional mud hut with thatch just to keep the plot but again I hear that there is a basic house design that has to be constructed in the plot so the traditional house plan may not work to keep the plot for me either."(Kaone, aged 35)

Although on one side the government has undertaken these developments to ensure orderly, efficient, cost effective and sustainable urban development, on the other side the developments have 'posed as an obstacle to the poor's ability to home ownership' borrowing Datta and Jones (2001)'s words. Moreover, the government's removal of subsidies[63] on urban land ownership has consequently made the poor's participation in home ownership even more difficult and has exacerbated the problem of housing costs as the poor has to pay not only for the land costs but also for the interest charges on the loans. This is because in principle, housing subsidies increase the ability of a household to pay for better housing therefore the lack of subsidies means it is difficult for PPLWHA and other poor people to afford quality housing hence they find themselves in substandard housing which further compromises their already poor health.

The insights from the PPLWHA in this study indicate that in the absence of housing finance assistance suitable for them, it is difficult to develop housing of adequate and healthy standard. Very few, if any, of PPLWHA who are plot holders manage to obtain building material loans either from SHHA or from any other financial institution. Plot holders therefore have to raise money under difficult conditions in order to develop their residential plots.

5.4 SUMMARY

This chapter discussed the housing problems faced by PPLWHA in Gaborone and was guided by the critical realism theoretical framework adopted in Section 4.3. The chapter primarily argued that the housing problems faced by PPLWHA are determined by the various complex processes, structures, powers and causal mechanisms which interact and ultimately produce or contribute immensely to the housing problems and constraints experienced by the PPLWHA.

From the outset of the chapter in section 5.1, an overview of the dwelling forms sorted according to housing tenure which are used by the twenty six PPLWHA interviewed in this

[63] When the SHHA programme was initially established in the 1970's until the 1990's, it was hugely subsidised; SHHA plots were allocated virtually free of charge to low income beneficiaries. Building loans that were given to the SHHA beneficiaries had subsidized interest. Building control was relaxed as SHHA beneficiaries were required to build at least a habitable room and a pit latrine. However, due to the high cost of servicing the land, the Government has since started to charge SHHA beneficiaries a recovery cost to cover for services provided for the land. A minimal interest rate of 10 percent on the SHHA building material loan has also been added hence Datta and Jones (2001) argue that the subsidies have been stripped off the low income people and making it difficult for them to own houses.

study was presented to provide a descriptive picture of the types of housing conditions that the PPLWHA reported to be living in. Despite that PPLWHA lived in houses that vary in type and quality within the various housing tenures; generally, they lived in poor housing environments. Commonly, most of PPLWHA lived in shared plots within a shared single room which is not only shared by several people but also used for sleeping purposes as well as all other domestic activities. The lack of housing affordable to the needs of the low income people in the formal housing market has compelled PPLWHA to live in the informal housing areas characterised by poorly constructed and unsanitary housing. The relaxed enforcement of the building control codes and development standards on the informal housing have led to the usage of poorly constructed housing structures particularly by the poor people and therefore putting the health of the vulnerable people including PPLWHA into further compromise. The high level of sharing that is common in the informal housing by PPLWHA has created a problem of crowding which consequently produced poor housing conditions within the shared rooms and furthering the health risk of both PPLWHA and the other people sharing within the various spaces because crowded areas provides an environment for transmission of communicable and enteric diseases particularly those associated with HIV/AIDS such as tuberculosis and skin diseases.

In responding to their poor housing conditions some of PPLWHA adopted desperate measures to cope with their problems consequently compromising their health. The dependence of females on male partners for meeting their shelter needs was common in this study despite that in the era of HIV/AIDS, this dependence has the potential to extend into the women's lack of control over the circumstances in which intercourse occurs hence making them susceptible to HIV/AIDS infection and re-infection[64]. Some PPLWHA resorted to engaging in income generating activities such as being informal landlords and selling alcohol in their residential areas which, added to the over-crowding in their plots, therefore exposing them to poor environmental and social problems related to crowding. It is important to recognise that households have not remained passive in the face of HIV/AIDS but have generated strategies intended to overcome their housing difficulties.

[64] HIV re-infection, also called HIV superinfection, is when a person who is already infected with HIV acquires a different strain of HIV. That person may have acquired both strains simultaneously from a dually infected partner or from multiple partners. For details on HIV re-infection see Smith et al (2005)

Section 5.2, guided by critical realism theory, gave an insight to the underlying structures that have the potential causative powers to the housing problems faced by PPLWHA. Poverty and HIV/AIDS were found be the main observable structures that contribute to the housing problems faced by the PPLWHA and formed the 'real domain' of critical realism. Interestingly, the PPLWHA did not find HIV/AIDS as an inhibiting problem to them, however confirmed unanimously that poverty is their key problem which puts them into compromised housing situations. The administration of the ARV's could be attributed to the perception made by the PPLWHA as their positive result overshadows the long-term effects on their lives. Of great importance is to note that the sustainability of ART in Botswana is uncertain due to local and global changes such as economic decline. In the event that the free ART programme is disrupted, the impact will be felt more and foremost by PPLWHA as they will definitely be at a disadvantaged position to afford the ART at personal level (for lifelong adherence) due to their already established poverty and economic problems.

The section further argued that the housing problems faced by PPLWHA have not been due to one single factor but rather are due to an intersection of several factors including land and housing provision in the country especially issues related to housing market regulation and control, affordability, security of land and housing tenure and access to housing finance. As Fitzpatrick (2005) observed realist explanation of actual social events and phenomena are not 'mono causal' and deterministic but are rather 'complex' with loops linking multiple causal mechanisms.

Affordability problems emerged as the key factor that inhibit PPLWHA from participating in the formal housing market hence pushing them to living in poor housing environments in the informal housing market. However, the administrative structures within the formal land and housing market were found to be a hindrance to access to decent sanitary housing for PPLWHA. These included high rental cost which by implication discriminates against the PPLWHA who have meagre income and limited resources which are competed for by all basic needs vital for their health; discriminatory eligibility criteria which require formal employment hence discriminate against PPLWHA who generally are engaged in informal employment; and lack of priority through allocation criteria to vulnerable people including PPLWHA.

Finally, this chapter argued that the fundamental cause of poor housing for PPLWHA can be high housing costs coupled with the implementation of rigorous housing standards in urban areas in Botswana which are unaffordable for PPLWHA. The current costs of infrastructure and associated costs related to set codes, standards and procedures are inappropriate to the housing requirements of the low-income population especially in the absence of the housing subsidies to reduce the housing costs of the low income households.

Furthermore the gap between the housing financial products that low income households want in order to upgrade their housing and the financial products that are supplied also need to be considered thoroughly as the housing financial support is simply not accessible in the shape and form that low income households can best use. It is therefore of great importance for the policy makers to recognise the role of good housing for PPLWHA hence provide intervention strategies as well as regulatory measures to protect them from exploitation by the housing providers.

5.5 CONCLUSION

Despite the small size of this sample and the purposive manner in which it was selected, some evidence emerges that housing occupies an important place in the various causal chains linking poverty and inequality, HIV risk and outcomes of HIV infection. Housing, or rather lack of adequate housing, is powerfully linked to the exposure to risk and transmission of HIV, as well as to the care and health of people living with HIV/AIDS. Improvements in housing are associated with reduced HIV risk and improved health care outcomes. This chapter revealed that the lack of housing can affect one's risk of contracting HIV/AIDS and hence stable, sanitary and adequate housing becomes especially critical for PPLWHA. Poverty has been identified as the link between housing and HIV/AIDS, to the extent that the poor put themselves in vulnerable situations and conditions in order to access housing. Despite the evidence that poverty and lack of access to housing are closely related and that the lack of access to housing can be interpreted as a potential cause of heightened risk of contracting and exacerbating the condition of HIV, public assistance reforms tend to put more focus on medical needs for PPLWHA and ignore the housing need and related services in their HIV/AIDS and poverty interventions. The campaigns of prevention and control of AIDS and of poverty reduction in Botswana have not been matched by the campaign that links the trio of housing, poverty and AIDS.

Hence PPLWHA live in poor housing, which further compromises their health. What this chapter shows is that the connection between housing, poverty and HIV/AIDS should be fully explored and incorporated into HIV/AIDS interventions because of the housing conditions in which many Batswana live. Key features of housing poverty such as overcrowding, insanitary housing conditions and poor sanitation must therefore be closely examined to reveal more information on their contribution to HIV/AIDS. Indeed, housing warrants a more focused attention as a structural factor which directly or indirectly affects an individual's ability to avoid exposure to HIV as well as being used as a health promoting and risk reducing resource. The poor standard of living of PPLWHA in Gaborone deserves special attention from both the health and the housing services and should be considered as an integral component of strategies aimed at controlling the HIV/AIDS epidemic.

It is clear, from this chapter, that access to sanitary and affordable housing is influenced by factors far beyond any single individual's control. Housing provides a clear example of the ways in which broader economic and political factors shape the general context of health and especially HIV/AIDS, which is the focus for this study. The chapter highlighted the fact that having a secure and appropriate place to live is affected by the existing stock of affordable housing, and the support from a range of political and economic policies and institutional practices that shape the accessibility and availability of housing. As poor households tend to have modest means, there is a low likelihood of them accessing housing through the housing market by way of purchase, building or even renting in that housing policy fails to satisfy other needs. As a result, poor people resort to adopting behaviour that not only exposes their already compromised health to further infection from related opportunistic diseases but also to exposure to re-infection as they either rely on male partners (whose HIV/AIDS status they don't know) for housing provision or settling for poor quality housing that is unsuitable for human habitation or else adopting livelihood strategies that compromise their health. Public health and poverty reduction responses and policies should have housing as a fundamental component and be involved in expanding access to safe and sanitary housing.

Although the focus of the chapter is the problems faced by PPLWHA, it should be pointed out that the conditions that promote housing tenure insecurity for PPLWHA are varied and very broad indeed. Mounting land pressures, absence of sufficient housing finance, and the

HIV/AIDS epidemic itself, combine to form a situation in which different people living with HIV/AIDS are affected in various and complex ways. Consequently, PPLWHA must be assisted with good quality housing because on balance, the benefits of the assistance outweigh the costs of not doing so. While this present study is mostly informed by women (25 women and only one man), it is important to recognise that the housing problems are gender blind and any response to housing insecurity in the context of AIDS must also take men into account.

Furthermore, the 1996 United Nations Conference on Human Settlements or HABITAT II as it is more commonly known, reaffirmed adequate housing as a fundamental human right. As King (2003:46) argues, rights can be 'pious statement of intent or manifesto claims that have no validity and have little meaning' if they are not backed by the institutions of the state for concrete action. Adequate housing is essential for human survival with dignity. Without a right to housing, many other basic human rights will be compromised including the right to health and privacy, the right to freedom of movement, the right to health and the right to development. Unfortunately, turning rights into realities can be difficult. Human rights should be binding obligations but for many rights such as that to an adequate standard of living compliance depends on resources. Some people because of lack of resources, specifically financial resources, are forced to forego their rights and hence the need for some special provision and PPLWHA form part of that vulnerable group. The next chapter will therefore address the research question which asks what intervention strategies the lands and housing policy makers and other housing stakeholders have put in place to assist poor people living with HIV/AIDS in Gaborone.

CHAPTER 6: HOUSING INTERVENTIONS FOR POOR PEOPLE LIVING WITH HIV/AIDS

6.1 Introduction

The foregoing discussions argued that the determinants of vulnerability to HIV/AIDS are rooted in poverty, unemployment, gender based inequalities, and access to resources. In a similar tone, the discussion pointed out that housing problems that PPLWHA are faced with are primarily due to constraints in access and affordability of housing and related services owing to poverty, unemployment, gender inequalities and the critical lack of affordable, safe and sanitary housing. It is the purpose of this chapter to discuss how the government and non-governmental organisations in Botswana have responded to the housing problems faced by PPLWHA. This will be achieved through analysing the policies and programmes aimed at the provision of housing for the poor. It is important to highlight that there is no specific housing programme or policy that addresses the housing needs of PPLWHA exclusively but their housing needs are considered collectively with those of the general poor people in Botswana. The remainder of this chapter is divided into four sections arranged as follows:

Section 6.2 starts by sketching out some background of the specific housing programmes that are designed and implemented by the Botswana government to provide housing for the poor and low income people in urban areas. This is necessary to set the context. Drawing from the preceding chapter, the discussion proceeds to explore how the government have integrated HIV/AIDS into their housing programmes in order to accommodate the housing needs of the poor in general and PPLWHA especially, considering the problems that PPLWHA have raised in the preceding chapter. The discussion is primarily based on the interview data provided by the lands and housing policy makers and other providers of housing related services in Gaborone. The data is supported by secondary data from the related policy documents and other literature.

Section 6.3 presents evidence of the involvement of the non-governmental and community based organisations in the provision of housing for PPLWHA. The section starts by setting context by outlining the various non-governmental organisations that are geared at housing provision for the poor in Botswana before moving on to discuss how these organisations facilitate the implementation of the housing policy aims regarding housing the poor. The discussion then develops to evaluate the underlying factors and/or structures that are apparent in the housing delivery market that have the potential to pose constraints to the NGOs' and CBOs' contribution in addressing the housing problems forwarded by PPLWHA in chapter 5. Similarly to the preceding section, the discussion is primarily based on the interview data provided by the relevant personnel and is corroborated with secondary data from the related policy documents and other literature.

Section 6.4 gives a summary of the chapter while section 6.5 draws conclusions on the chapter evaluating the effectiveness of the various housing initiatives designed and implemented to meet the housing needs of PPLWHA in Botswana giving specific reference to how they have responded to the housing needs of PPLWHA.

6.2 Governmental Housing Programmes for the Low Income People

Chapter 3 discussed various interventions focused on improving the health of PPLWHA in Botswana. However, the same chapter revealed that whilst good quality, affordable housing essential for improving the health and quality of life of PPLWHA, in Botswana housing is yet to be acknowledged and connected to health, particularly as a means that could be beneficial in the control and management of HIV/AIDS. The intention of this section is therefore to examine how the government of Botswana is responding to meeting the housing needs of PPLWHA. For as long as the Botswana's National Housing Policy has been in existence (since 1982), the overall aim of the Botswana government has been to ensure that every citizen has access to 'safe and sanitary housing'; an aspect that is important and necessary in the care of PPLWHA. The findings in Chapter 5 have indicated that the aims of the policy have been achieved for some citizens but not for others, especially PPLWHA who still live in unsanitary housing conditions despite their compromised health. Nevertheless, in attempt to achieve its aim, the government has implemented various housing programmes for housing the poor and the low-income people. The Self Help Housing Agency (SHHA) and The Turnkey Development Scheme are specifically aimed at the low income people while people who fall below the SHHA

threshold are catered for through the Integrated Poverty Alleviation and Housing Scheme and the Destitute Housing Programme. These will be discussed in detail in turn, except for the Destitute Housing Programme which is limited to the rural areas hence falls outside the aims of this study. SHHA programme has been by far the major programme for housing the low income people in urban areas. Based on that, most of the chapter will be focused on SHHA while the rest of the chapter will analyse the rest of the programmes.

6.2.1 Housing the Low Income through Self Help Housing Agency

Since its inception, SHHA has been the only formal avenue in Botswana through which low-income households gain access to housing in the conventional housing market. As outlined in Chapter 3, SHHA was introduced in the 1970s with the main aim to provide urban residents with an effective means which allows access to affordable housing for the low income people who were left out by the conventional housing providers. The programme followed the concept of 'aided self help'[65]. During its inception, the programme was heavily subsidised and it provided its beneficiaries with: a residential plot which had a secure tenure known as Certificate of Rights (COR) free of charge, housing finance with a subsidised annual interest rate of 10%, supervision and assistance with the housing construction. According to Mosha (1995), initially SHHA plots had flexible planning laws which were provided by the Town Planners to suit the needs of the low income. Due to the relaxed building standards, SHHA beneficiaries could even build the houses of very minimal quality which could be argued to have been insanitary as one of the Housing Officers commented:

> "At the beginning of the programme, the land that was allocated to people was serviced at very rudimentary standards like pit latrines for sanitation. There were some concerns that this was not suitable for the wellbeing of people." (Housing Officer, DoH)

Indeed, the housing environment within the SHHA program initially was neither of satisfactory quality nor condition and was a health hazard hence there was a need to review some of the standards of the programme. However, the revised Urban Development

---

[65] Self help housing is a term that has been used to describe the participation of low income households in the production of their own housing. The main difference between self-help and conventional housing is that houses can be occupied before they are fully developed. Self help housing has the advantage that it is flexible; therefore the poor can develop their houses over time. The urban poor can develop their houses gradually because it will result in lower labour costs as compared to conventional housing, because they would invest their own labour in the construction process.

Standards of 1991 introduced a review of the SHHA program which is commonly known as the 'New SHHA'. Table 6.1 provides a summary of the developments made during the review from the 'Old SHHA' to the 'New SHHA' plots.

Table 6.1: A comparison of the old and new SHHA plot standards

	Old SHHA Standards	**New SHHA Standards**
1. Plot Size	400 to 450 Sq Metres	200 to 375 Sq Metres
2. Sanitation	Pit Latrine, 1 refuse bin per 2-5 plots	Waterborne sewerage,1 refuse bin per plot
3. Water	1 communal standpipe per 20 plots	Phased out communal stand-pipes. Water reticulation to plots
4.Infrastructure	no electricity, gravel roads	Electricity easily connectable. Tarred road and improved gravel roads
5. Building materials	Cement and Corrugated iron (relaxed to the use of temporary material such as mud and thatch)	Strictly permanent materials such as Cement and Corrugated iron
6. Building Regulation	Flexible planning laws which were provided by the Town Planners	dwelling structure to conform to the Statutory Development Control Code and Building Regulations

Source: Annual Report SHHA 2005

It is important at this point to note that with the review of the SHHA programme some of the housing that was constructed during the old programme was upgraded to an improved quality while some are still of low quality and being used by PPLWHA and other poor people as highlighted in Chapter 5. The review of the SHHA programme was indeed a

necessary development which was beneficial to both the government and the SHHA beneficiaries. To some extent it reflected the government's concern for improvement of the lives of the low income people; particularly because it introduced improved housing and related services that are essential for the health of the users. However, this review removed the most needed subsidies for the low income people hence making the programme, unaffordable to some low income people. For context, Table 6.2 presents the specific changes that were introduced with the new SHHA programme.

Table 6.2: A summary of the requirements for the old and new SHHA

	Old SHHA Requirements	**New SHHA Requirements**
1. Income Range	P1800-P10000 per annum	P4,400 and P24,300 per annum(for lower income plots) P24,301 and P36,400 per annum (for middle lower income plots)
2. Source of Income	Formal employment legitimately self-employed	Formal employment legitimately self-employed
3. Plot Price	Allocated free of charge. Holder pays a portion of development costs in service levy	Affordable prices
4. Land Tenure	Certificate Of Rights	Fixed Period State Grant
5. Registration	Government is registered owner of land. Holder is registered with the Town Council	Owner is registers in Deeds Registry, in terms of a 99 year lease.
6. Building Materials Loan	Maximum P1,200 at 9% per annum paid within 15 years	Maximum P45,000 at no interest for those without arrears; and 10 % interest on arrears per annum. Paid within 20 years
7. Recurrent costs	Plot holders pay service levy	Owner pays rates
8. Mortgage and Loan Security	COR can't either be used to register a mortgage or ceded as security for a loan.	Owner may register a mortgage against a plot

Source: Annual Report SHHA 2005

While the review of the SHHA programme was modest in many ways, the new programme presented several constraints to the low income people in general and PPLWHA especially primarily associated with (a) access to land, (b) affordability and (c) security of land and housing tenure which have, to an extent, made it difficult for PPLWHA to live in safe and sanitary housing and for the government to achieve its main aim of providing safe and sanitary housing for all citizens. These factors are discussed below in turn.

a. Access to SHHA residential plots by PPLWHA

Land is inarguably the most critical and foremost input in housing. However, as Ikgopoleng and Cavric (2007) argue, the urban poor in Botswana often find it difficult to access land to meet their housing need in urban areas. PPLWHA in this study who fall within the SHHA threshold reported that they have a problem of lack of access to residential land in Gaborone. In response to the issue, the main land providers indicated that there is generally an acute shortage of serviced land in Gaborone, which affects not only the low income people but the general public in Gaborone. The Director of Lands said:

> "...we (*The Department of Land*) don't have enough land left for allocation to people, especially in urban areas." (The Director, DoL).

In a similar tone, the Gaborone SHHA Officer also commented:

> "In Gaborone, the applications for SHHA plots have been suspended since 2004....We have not made any allocations since then because there are no available plots for allocations in Gaborone."

The land shortage is not a new thing in Gaborone. In the early years of SHHA there was an acute shortage of land to which consequently, in 1987 the government responded by introducing the Accelerated Land Servicing Programme (ALSP) with the intention to speed up the supply of serviced land into the housing market and improve land accessibility in Botswana. Since land is a natural resource that gets depleted and is irreplaceable, the plots that were since made available by the ALSP have been used up and the problem of lack of serviced land has re-surfaced. Consequently SHHA plot allocation has been put on hold. The halt in land allocation will inevitably have a cumulative effect upon people on the waiting list hence increase the already high demand for low income land in Gaborone. The lack of serviced land is currently a major problem for the

government of Botswana that needs to be addressed urgently and carefully and as the National Housing Policy (2000:6) states:

> "...there is a need to acquire more land for expansion of urban areas, particularly Gaborone."

Provision of land for housing is complicated by the fact that land has many uses other than shelter. Housing competes for land with industrial, commercial, administrative and recreational uses. Furthermore, Grimes (1976:42) argues that some land owners may hold vacant land off the market in anticipation of larger gains in the future. This practice was observed in this study as one person indicated that she owned four residential plots which she reserved for her family's future needs.

> "I live on my own plot, I bought the plot from one of my relatives....I have three other plots; one which I acquired formally in the outskirt of the city, the other two are in my home village. I got one from a formal allocation and the other I inherited from my mother when she died.....I will keep one in the village for myself, give the one in the city outskirts to my son and the one in the city will be for income generating while the one I inherited I will transfer to my youngest sister when she is of the age required for land ownership."

This aspect of land hoarding has the potential to restrict the supply of land for housing development. While the lack of serviced land is clearly a problem, it is not the only factor that hinders PPLWHA access to housing in urban areas. There are some other underlying factors that contribute to the problem, particularly those that were introduced with the revised SHHA programme. They include: land cost; development and building regulations; building materials, all discussed below in turn.

b. Affordability of SHHA plots for PPLWHA

Land price is a major factor that determines the use of land for housing. If land is made available at unduly high standards and prices, poor families may not benefit adequately from the land market. The government of Botswana through its pricing policy for serviced land; allocates land through full cost recovery whereby first time buyers of residential plots pay 'full cost recovery price[66]' and low income (SHHA) beneficiaries pay 'affordable

[66] Full cost recovery price has been defined as the price which has been calculated to ensure recovery of all costs related to servicing of land including an economic return on resources, recurrent servicing, maintenance and overhead costs accrued during the housing project life (Ministry of Local Government, Lands and Housing, 1990: 68).

prices[67]' (Government of Botswana, 1992; Nkwae and Dumba, 2009). Pricing the serviced residential plots has got its benefits as well as some weaknesses. It is important and beneficial for the government in terms of recovering the costs incurred servicing the land and it also provides the beneficiaries with land that has improved services as already discussed. However, despite the fact that the plots are sold at affordable prices, they still remain beyond the financial reach of some of the low income people particularly the PPLWHA whose financial priorities have been shifted to focus more on their health.

The high land price has been criticised as the major weakness of SHHA for the reason that it excludes those urban poor without any source of income and those employed in the informal sector where wages are low and irregular hence they fall below the SHHA threshold and this includes most of the poor people living with HIV/AIDS in this study (Kerr and Kwele, 2000; Datta and Jones, 2001). Furthermore, there are underlying financial costs that exacerbate the already expensive housing costs, including the enforcement of building standards on SHHA plots and the use of modern building materials. These are all discussed below in turn.

c. Controls on building standards on SHHA plots

Appropriate building standards are essential to the creation of a safe and pleasant environment. However, if the set standards are too high, they tend to be unaffordable in the long term for the poor people. SHHA beneficiaries are required to use an approved house plan which is in compliance with the Development Control Code and the Building Control Regulations. This was emphasised by the Housing Officer who said:

> "SHHA beneficiaries must have developments in their plots as per the house plans that meet the legal building requirements. However, they have a choice to bring their own plan or choose from the few plans we have here. We have good house plan which are also affordable as compared to the plans developed by private architects.... The development should be according to the house plan approved by the Council and all stages of construction need to be inspected to meet the building standards." (Housing Officer, GCC)

Even though the building standards may contribute positively to the development of safe and sanitary housing required by PPLWHA, if misconceived, these building standards can

[67] Affordable prices are set in relation to the income levels of the residential plot applicant. It is defined as a price that potential buyers can afford to pay without the benefit of a subsidy. This is calculated as being no more than 25% of the total monthly income for a low-income household (Ministry of Local Government, Lands and Housing, 1990: 68).

contribute to depressing their living standards. Poor people who are desperate to meet the required housing standards may compromise their meagre incomes by spending it on housing construction that meets the required legal building standards and disregard their other essential basic needs such as healthy food and medical needs. For a poor person living with HIV/AIDS, compromising the much needed healthy lifestyle (including balanced meals and medical needs) will further compromise or even lead to a deterioration in their already compromised health.

Furthermore, the SHHA plots must have connection to utilities (on-plot water and electricity) and water-borne sanitation which are all a legal requirement for all new low income plots. Whilst this is a laudable concept, it can be unaffordable to the beneficiaries. Electricity and water connection on individual plots is convenient but costly, more so where there are no subsidies to help those with affordability problems. The low income people may afford the initial cost of providing these required services but may prove difficult to sustain in the long-term. Ikgopoleng and Cavric (2007:34) reported that a significant number of SHHA dwellers have the problem of maintaining the utilities on their houses, and had electricity and water disconnected at one point during their tenancy due to unaffordability problems. The disconnection of basic utilities, particularly water which is needed for sanitation facilities (which is a legal requirement on plots) has the potential to contribute to the decline of sanitation in the new SHHA. This will create a major health hazard for the general population on the plot and PPLWHA especially. For instance, the disconnection of water on the plot implies that there will be lack of running water for toilet facilities in the house while, on the other hand, the pit latrines which could provide an alternative on the plot are prohibited by law.

d. Building material required to construct houses on SHHA plots

Building materials form an important component in the housing construction process and their contribution to the low-income housing in particular cannot be over-estimated. The PPLWHA raised a concern over the provision of affordable building materials. PPLWHA highlighted the cost of building materials as one of the main constraints that hinder them from developing sanitary housing especially that the use of traditional building materials is not permitted by the Development Control Code and the Building Control Regulations. One of PPLWHA commented thus:

> "The government contributes to this by devising requirements that makes it even more difficult for the poor to develop the plots by introducing the building standards and building plans. Traditional houses are the only houses that poor people could develop without getting into debt but the government don't want them and need modern houses with house plans and meeting certain set housing standards" (Kago, aged 40).

The building standards seem not to support the usage of traditional building material, it requires the use of modern building materials such as corrugated iron, roof tiles, cement to mention a few. However, the use of these modern materials needs skilled personnel to use them, which further adds on the already high cost of housing hence making housing development unaffordable.

Ironically, in theory, the Government of Botswana encourages the use of traditional building materials, as outlined in the current National Housing Policy stating:

> "....the government should institute appropriate measures to encourage the use of available local materials in order to reduce building costs." (p.23)

SHHA programme also encourages the use of traditional building materials provided that they achieve an acceptable quality and durability (Mosha, 1995). However there is no evidence of the government supporting the implementation of use of traditional building materials as outlined in the policy.

The notion of use of traditional building material seems appropriate and affordable to suit the financial capacity as well as the health needs of the low income people in general and PPLWHA especially. In a hot country like Botswana, a thatched[68] roof will provide more insulation than the corrugated iron roofs hence beneficial for thermal comfort needed by PPLWHA. However, the reality is that although desired, good quality and durable traditional building materials (notably moulded clay bricks for walls and plastering and good quality thatch for roofing) are not available in urban areas. Consequently this will make traditional building materials more costly than modern building materials, both in the short term, due to the cost of bringing them from rural to urban areas and in the long term due to maintenance cost which will indeed increase the overall cost of housing construction for SHHA beneficiaries. The Programme Manager of Habitat for Humanity Botswana echoed this by commenting:

[68] Thatch is a natural insulator; air pockets within straw thatch insulate a building in both warm and cold weather. A thatched roof will ensure that a building will be cool in summer and warm in winter.

"The building materials used to be quite easy to access and use.... mud and thatch. These days it is not easy to get the indigenous building materials, from the assessment that I have made, to give an example, there are two types of thatch used here in Botswana, the grass one and the reed one. Amazingly, local people can no longer afford the reed type of thatch; you find it in expensive, posh restaurants and other tourist attraction areas, and that communicates something. So, the houses that were built by individuals using that kind of thatch are very old ones which are now dilapidated structures. That shows that in the olden days it was probably easy and accessible to acquire that kind of thatch. Now it comes with skill and costs such as transportation costs and many other related things; this has rendered that indigenous building material unaffordable to most local people. The comparisons that I have made with respect to the building materials are that corrugated iron is much cheaper than thatch."

e. The conversion of COR to FPSG

When allocating a piece of land, it is necessary to tie it to some form of tenure in order to safeguard the plot holder against possible future claims. In that respect, the Botswana government have been offering the low income people in urban areas the security of land tenure through the use of Certificate of Rights since the inception of the SHHA programme in the 970s. COR provided a secure and inexpensive form of tenure tailored to support the site and service schemes for the poor (Nkwae and Dumba, 2010:3). This was (and still is) a laudable thing as the tenure is secure, perpetual and inheritable. However, it can't be sold nor mortgaged as the government maintains its ownership. COR was created before HIV/AIDS was an epidemic in Botswana; however, it seems to have been suited for the effects of HIV/AIDS. Of particular interest is the inheritable land rights attached to it which are important especially for plot inheritance by the AIDS orphans in case of any eventuality (this is possible for SHHA beneficiaries who lived up to the agreement and are not in arrears). However, the 1992 review of the SHHA program phased out COR and replaced it with Fixed Period State Grant (FPSG) with the aim of providing a simple, improved form of land title that would be accepted as collateral by financial institutions (Ikgopoleng and Cavric, 2007). This conversion has been found to be difficult for the poor because of the following: firstly, the cost of converting COR to FPSG is unaffordable to most of the low income people (as already outlined in chapter 5), and secondly, strict measures of building on a FPSG plot are unaffordable for the poor due to their current low levels of income.

The SHHA programme provides land and housing finance. SHHA plot beneficiaries in urban areas automatically qualify to apply for an interest free SHHA loan which currently amounts to up to a maximum of P45 000 payable over 20 years. Interest is charged only on

arrears (Government of Botswana, 2009). Although the loan is relatively cheaper than at the commercial bank, the rate of default has been a major problem reported on SHHA loans. Hence the housing officers emphasized:

> ".....the level of arrears on SHHA loans is very high. It was estimated at one time that about two thirds of all the households who took out the loan were in arrears at any one point in time, which is 60 per cent, a really high proportion." (Former Housing Officer, DoH)

> "The default rate in all the councils, you will find that it was very high. I cannot say exactly why the default rate is as it is." (Housing Officer, GCC)

The legal position is that SHHA houses that owe money are to be repossessed in order to recover the loan as outlined by the State Land Act and emphasised by The Housing Officer (DoH) who said:

> "We are to apply the State Land Act which has a section that deals with the collection of monies owed to councils, be it SHHA loans or service levy, so there are certain processes which are to be followed to enforce that including repossession of movable property. In the event that the money owed is more than what can be recovered from the sale of movable property, the immovable property can actually be sold; for example the house."

However, there has been some degree of leniency on repossessing either the SHHA plot (on COR) or houses built from the SHHA loans. The Housing Officer further indicated that repossessing a basic need such as housing from low income people will be source for socio-economic strife and would also attract political interest. He said:

> "We delay to repossess the plots or sell the house to recover the money owed because we are bound by the mandate of SHHA, which is to provide housing for low income people. All we do is to urge the person to pay all the money owed."

The Former Housing Officer (DoH) echoed this by saying:

> "It is possible that the repossession can come in if the SHHA beneficiary doesn't service their loans.... the legal position is that the plots must be repossessed. However, in practice sometimes administration gets tied up with politics, for example, so the whole process can be quite lengthy. It is not a very straight forward thing. Before repossession can take place, it will have to go to the council committee which has councillors and SHHA management, that's where the decisions are taken."

Although PPLWHA in Chapter 5 suggested that they feel vulnerable to lose their land and housing tenure to the government due to repossession, the data from the policy makers highlighted contradicting results. The housing policy makers suggest that although land and housing repossession are possible in theory, they are practically not as easy to

implement as due to the political influence and control associated with the administration of SHHA programme.

Part of the reason for converting COR to FPSG tenure, as highlighted in the foregoing discussions is to assist the beneficiaries to be able to use SHHA plots as collateral for the mortgage. However, the security of tenure on the SHHA plot has an increased potential to be lost to the financial institution which provided the mortgage predominantly due to the beneficiary's failure to make the loan repayments. The poor people living with HIV/AIDS have the vulnerability to this loss as they have the increased potential to lose their income hence fail to pay the mortgage due to health reasons. Unlike the public institutions, private and commercial banks have more stringent measures regarding loan defaults that are not particularly based on compassion but are business oriented. Furthermore, as observed by Nkwae and Dumba (2010) commercial financial institutions in Botswana are not willing to provide loans to the low-income groups as they are often regarded as risky and prone to default. This is evidenced by the SHHA loans offered by the government which lack insurance cover due to this assumption as discussed in the next section.

f. Security of Land tenure and Land rights in SHHA

PPLWHA interviewed for this study highlighted that they feel vulnerable to losing the security of tenure for their plots due to the lack of financial capacity coupled with the government's land regulatory measures that inhibit them to develop their plots. The government has since introduced the FPSG with the anticipation that the conversion to the long-term leasehold will attract other financial institutions to partake in providing home loans and assist the low-income people to develop their housing. Whilst the government anticipated that FPSG is an innovative and workable tenure system best suited to facilitate delivery of land and housing finance to the urban poor, it seems to have some limitations that contribute to the low income's vulnerability to loss of land and housing tenure.

g. SHHA home loan insurance

Mortgage insurance plays an important role in housing, primarily as a risk-sharing mechanism. It is defined by Bardhan et al (2006:9) as a legal insurance policy which on one hand protects the financial interest as well as reduces the risk exposure of the financial lenders against loss in case the borrower defaults, while on the other hand it protects the

borrowers from the risk of loss of property if they cannot pay their loan for any particular reason, such as due to death or involuntary unemployment. In responding to the impact of the epidemic, PPLWHA constantly seek security for both their own welfare as well as those of their children and dependents (Nkurunziza and Rakodi, 2005) hence the importance of having home loan insurance. In the advent of HIV/AIDS when life expectancies were short and drug treatments more expensive, access to mortgage insurance was prohibitive. Various companies and organisations performed mandatory[69] HIV/AIDS screening on the potential clients for different reasons including for insurance purposes or securing bank loans. However this testing did cause some controversy around the world related to human rights violation. One of the debates was largely on 'insurance for mortgage loans' because prospective customers were required to undergo an HIV test in order to qualify for mortgages of particular amount of money. However this aroused some critics as highlighted by one of the HIV/AIDS advocates who commented:

> "We have been arguing that HIV/AIDS should not be a yardstick for anybody to access any services in Botswana... the only issue had been on mortgage insurance where people had limitations on the amounts of money that they can be offered due to their positive HIV status. The issue has been going on in some public debates." (Research and Advocacy Officer, BONELA)

There has since been a shift with regard to the mandatory HIV testing for mortgage insurance in Botswana. Although the HIV has not been completely lifted off the mortgage insurance, the mortgage amounts that requires HIV testing has been increased. For instance, the Research and Development Analyst for National Development Bank said:

> "Obviously HIV/AIDS is a concern to the insurance companies. But, what we have done is that we have managed to negotiate to appoint whereby a threshold for testing is on the higher end, for example, loans above P700 000 (seven hundred thousand) will be subject to HIV testing. Any loans below P700 000 (seven hundred thousand) are not eligible for an HIV test. So it's not mandatory that someone who is getting a loan below P700 000 (seven hundred thousand) undertake an HIV test... Initially the amount that required an HIV test was lower, now it has been increased. ...Most requests for residential loans in Botswana

---

[69] HIV/AIDS mandatory testing is the compulsory testing of specific individuals which is widely practised primarily for reasons other than HIV/AIDS prevention. Common examples of mandatory testing include pre-employment screening, and screening for insurance purposes or securing bank loans. Some countries require HIV testing for visa applicants, especially prospective immigrants, and for scholarship and fellowship applicants. Certain occupations require in service testing, such as sex workers who practise in regulated industries, and some countries require a negative HIV test result for military personnel deployed internationally on peace-keeping missions. Some of these examples of mandatory testing probably reduce HIV transmission; others yield little public health benefit but might further marginalise people infected with HIV (De Cock, et al, 2002:67).

(*commercial banks)* ranges between P150 000 to P350 000. We just set our target so that at least most of the applicants will get their loans without going through the HIV test."

Despite that in commercial banks, mortgages are not offered without insurance due to its importance as discussed earlier in this section; evidence gathered from the interviews indicates that SHHA loans are nevertheless without insurance. The lack of insurance on the SHHA loan is one of the biggest limitations which arguably undermine the security of tenure for the low income people. It is an indication of the lack of ability of the government to protect the land and housing rights of vulnerable people. In responding to this shortcoming, the housing officers acknowledged that although SHHA home loan insurance is necessary and relevant to accommodate the current changes particularly brought about by issues such as HIV/AIDS epidemic, it is generally unaffordable for the low-income people. The Housing Officer said:

> "SHHA loans have no insurance on them...there has been an oversight, maybe the thinking was that low income people cannot afford insurance costs.... Yes insurance need to be considered, but on the other hand it should be taken into account that low income people have problems of affordability hence issues of risk associated with offering insurance to low income people. Insurance costs are expensive and given the HIV/AIDS scourge, the insurance costs may be even high in order to absorb the risk." (Housing Officer, GCC)

This justification is to a larger extent correct in that low income people have affordability problems but it seems to overlook the fact that home loan insurance plays an important role for the housing tenure security of PPLWHA. As already discussed, this group has an increased potential to lose their income due to illness hence fail to make loan repayments and default consequently lose the security of tenure.

Furthermore, it is important to note that the loss of housing tenure does not only affect PPLWHA but in some instances even extend to the dependants particularly after the death of PPLWHA who was the breadwinner. In such cases, when there is nobody with the financial capability to inherit and service the loan, the house has the increased potential to be repossessed and the dependants lose their parental home which might have been their sole inheritance. This is a critical problem that needs attention particularly because there is a lack of a comprehensive welfare system in place in Botswana to address the housing needs of such vulnerable people. The Housing Officer confirmed this saying:

> "The SHHA loans don't have insurance, therefore if parents die; it is difficult for the dependants to take over the loan as in many times the dependants of the low income people don't usually have good paying jobs to enable them to inherit the loan repayments." (Housing Officer, GCC)

Similarly, the Former Housing Officer (DoH) emphasised this by saying:

> "I remember a few cases in the past where there were debates on what to do with plots or houses where we have children left behind because the parents or the breadwinners have died. Although I don't have figures, I think it is a problem that has affected adversely a number of households."

This is an indication that indeed the emergent problem and the need for a mechanism that will accommodate it and consequently protect the security of tenure of PPLWHA and their dependants. However, a former Housing Officer (MoH) indicated that the government have made prior attempts to persuade the insurance providers to cover the loans for the low income people without success hence even the reviewed SHHA loans are still without insurance protection. Because the insurance companies are commercial establishments, the Insurance Manager interviewed in this study justified this lack of insurance cover on the housing loans for the low income people by saying:

> "The low income earners in most instances will not qualify for some of these *(insurance)* benefits primarily because of their low salaries....there is a high concentration of risk at the low income bracket... Obviously an insurance company have to make money, so, when there are many claims coming through, it means they are not making money."

Although the need for home loan insurance to protect PPLWHA from loss of tenure security is indisputable, affordability has once again emerged as an underlying structure that prohibit them access to benefit from the home insurance scheme as it is the case with other financial providers. The Insurance Manager confirmed this by saying:

> "If you are taking these *(insurance)* policies, there is a cost because it is a product... The low income earners in most instances will not qualify for some of these *(insurance)* benefits primarily because of their low salaries....there is a high concentration of risk at the low income bracket... Obviously an insurance company have to make money, so, when there are many claims coming through, it means they are not making money."

This is a clear indication that the insurance companies do not appear to focus on the low-income people in any significant way. Although they don't explicitly target a specific income group they implicitly target the middle and upper income groups and exclude the low income group. This confirms what Nkurunziza and Rakodi (2005:23) observed that most commercial actors such as insurance firms perceive the poor as 'unattractive clients' because of their poverty.

Nevertheless, this is not to suggest that there is no role for commercial institutions in providing insurance measures to the low income and the poor. The insurance market is

currently accessible to these groups including PPLWHA to arrange for house insurance as discussed in the next sub-section.

h. Insurance for SHHA houses

A home is probably the single largest investment a low income family can make. Therefore, its protection from loss is vital and home insurance plays an important role in that respect.

There has been a shift with regard to mandatory HIV/AIDS testing for home insurance in Botswana. HIV/AIDS is not a restraint to access home insurance as highlighted by the Insurance Officer who said:

> "If one wants to insure their life, there is some form of limitation...but for them to insure their house there is zero restrictions as long as they can pay the premium. What the customer is basically saying is they want to insure their property in case of any problems such as burning down, there is absolutely no restriction on that one."

Regardless of the relaxed administrative requirements within the insurance market, protection of loss of security of tenure through home insurance remains a problem for PPLWHA due to their limited financial capacity and not their HIV positive status. There is therefore a strong need for intervention required particularly as there is a lack of a comprehensive welfare system in place in Botswana to address the housing needs of such vulnerable people.

Although the SHHA houses are hardly repossessed, as discussed earlier in this section, it is important to note that the loss of the house is not limited to repossession but may be through other ways such as being destroyed by fires and natural disasters. Therefore, in such instances the loss of a property without insurance will not only be a physical and financial loss to the affected family, but also to the government who would have lost the funds loaned to the low-income person and in addition have the responsibility to re-house the affected family in safe and sanitary housing.

Closely related to loss of tenure and HIV/AIDS is the problem of property grabbing. This has been highlighted as one of the problems faced by PPLWHA and their dependants. Although only speculative in this study, it gives an insight that it is a potential problem that needs addressing. Home insurance has the potential to manage this issue because the home

owner will clearly pronounce the beneficiaries hence reduce conflicts related to property grabbing upon any eventuality such as death.

The policy makers should attempt to react and embrace change as new problems emerge and circumstances change. The government of Botswana has to consider the issue of home insurance carefully particularly to integrate factors that have come into play such as HIV/AIDS. The housing programmes need to be adapted to be compatible with the current markets that have accommodated the current changes. As the Housing Officer (GCC) commented,

> "We are using some old practice which was never reviewed to accommodate change such as embracing HIV/AIDS"

Nevertheless, there have been new developments in the SHHA programme, including the implementation of the Turnkey Development Scheme discussed in the next section.

6.2.2 Turnkey Development Scheme

This is the latest governmental housing initiative provided for the low income people in urban areas. This programme was piloted in 2003 in an effort to establish the possibility of the government providing complete housing structures rather than a plot and housing finance to eligible SHHA applicants. The programme forms part of the revised SHHA (2008) and has adopted and implemented a 'Design and Build' housing development method to provide housing for the SHHA beneficiaries (Government of Botswana, 2009). In this scheme, the Local Authority builds a house not exceeding the value of P60, 000.00 for the beneficiaries who will then have to repay the cost in a similar way as the SHHA loan discussed in section 6.2.1. The terms and conditions are relatively similar to those of the SHHA scheme as outlined below:

> "The Turnkey development scheme entails construction of houses at a unit cost of P60 000 for beneficiaries who opt for a completed house. The repayment period for the loans under the scheme was also increased from 15 to 20 years at 0 percent interest, with 10 percent interest on those who default in repayment....The Minister of Lands and housing reported to the Botswana Parliament that the new housing scheme for the low-income class is set to deliver at least 1166 ready houses during the 2009/10 financial year" (Mmegi wa Dikgang newspaper, 9 May, 2009).

The Turnkey development scheme has been tailored to accommodate the housing needs of the urban poor and seems relevant to address some of the housing problems faced by the PPLWHA particularly that they indicated a desire to live in good sized homes with

separate spaces for different activities. The expectation is that the housing quality in Turnkey development scheme will be improved because the houses are built by the building contractors using an approved housing plan that meets the set building standards. The Turnkey programme will importantly bring diversity on the low income housing market which has been dominated by the SHHA programme. However, since the Turnkey Development Scheme is guided by the same terms and conditions as the SHHA programme, some of the same problems faced by PPLWHA in SHHA are inevitable in the scheme. For instance, these four key factors are foreseeable and need to be considered:

i. Affordability – do PPLWHA have financial capacity to buy and maintain a Turnkey house within their existing level of income?
ii. Accessibility- do the allocation requirements of the Turnkey scheme allow PPLWHA access to the scheme?
iii. Sustainability – are the beneficiaries protected to be able to maintain the ownership of their turnkey houses currently and in the long term?
iv. Suitability-is Turnkey housing the most appropriate way of addressing the current housing needs of PPLWHA?

Attention needs to be focused on finding out if the programme addresses these factors particularly because the Turnkey Development Scheme is directed by the same terms and conditions as the SHHA which to a larger extent failed to address some of the factors flagged above. As indicated in the foregoing discussion, to a larger extent SHHA have some underlying structural mechanisms that contribute negatively to housing PPLWHA as already discussed in section 6.2.1. The Housing Officers interviewed were reluctant to comment about the programme but expressed some reservations about it due to its current nature. One commented:

> "Some people prefer a completed housing structure over self building; however, I have a different view from theirs on this turnkey project...I anticipate problems.... Since this has just been implemented, the teething problems have not been identified. We will see how best to deal with them so that we don't run into problems probably by having some thorough educational sessions with the borrowers so that they can understand what they are getting into before they can sign any agreement. This will protect the council from liability and also to help the borrower to have an informed choice or decision." (Housing Officer, GCC)

The Housing Officers' reservation may be prompted by the previous experience on SHHA programme, particularly in terms of high default rate and affordability problems.

Nevertheless, Turnkey Scheme is a different programme with an aim different from that of SHHA, an informed discussion on the programme can only be possible after the programme has been tried and tested for some time. Also to note is that at the time of study, Turnkey scheme was not yet implemented in Gaborone; therefore none of the PPLWHA in this study were beneficiary of the scheme although they indicated that they have 'just heard about it' through the media'.

6.2.3 Integrated Poverty Alleviation and Housing Schemes

There are some people who fall below that threshold of SHHA and Turnkey Development Scheme and hence excluded from these programmes. To address that gap, the government introduced the Integrated Poverty Alleviation Housing Scheme with a primary aim to cater for them. The scheme entails facilitating economic empowerment of poor households by integrating skills acquisition, employment creation and income generation with shelter provision, as a strategy for poverty alleviation. It involves training the beneficiaries in the production and marketing of locally produced building materials to earn income and subsequently, constructing their own houses using skill acquired and income earned from the programme (Government of Botswana, 2000:17).

This programme is relatively new, it was started in 2002 and as the Housing Officer, (DoH) explained, 'its pilot took more time than planned' before it was rolled out to other areas in 2007'.

Similar to the Turnkey scheme, this programme is not implemented in Gaborone as yet hence none of PPLWHA interviewed are beneficiaries of the scheme. Nevertheless, since most PPLWHA in the study reported poverty as their main constraint to adequate housing, the model provided by this programme could be a relevant way of addressing the problem of poverty.

The issue of poverty alleviation has attracted both local and international attention over the years, leading to a more critical appraisal of methods used to tackle the problem. Hence the Government of Botswana is committed to a programme of poverty alleviation as one of its top policy priorities. Alexander (2002) however argues that poverty alleviation in Botswana is a policy issue that requires a multidimensional strategy driven by community-based structures that facilitate the active and real participation of the poor coupled with the political will and sufficient resource allocation by government. Based on that contention,

the assumption is that the aims of the Integrated Poverty Alleviation Housing Scheme will meet the housing needs of the poor people in general in the long term since the programme is newly implemented.

As UNDP (2002:4) rightly observed, in most countries only a handful of poverty reduction strategies adequately integrate HIV/AIDS. They further outlined that taking HIV/AIDS on-board will facilitate the creation of an enabling policy and resource environment for a comprehensive, multi-sectoral and scaled-up response. Similarly, The Integrated Poverty Alleviation Housing Scheme seems to ignore the housing needs of PPLWHA. As the epidemic is becoming one of the key obstacles in reducing poverty, any efforts and strategies to tackle poverty needs to embrace HIV/AIDS as the two are intertwined.

There is a need to recognise that although PPLWHA form part of the poor population, the poor are diverse and therefore programmes aimed at the poor need to consider separately the needs of specific groups particularly those who are vulnerable and disadvantaged in the society such as PPLWHA. This will help to increase access and alleviate deprivation. For instance, while the integrated poverty alleviation programme is potentially well directed to address the housing needs of the poor, it seems to ignore the needs of PPLWHA as it is labour intensive and consequently may exclude them. Evidence has suggested that HIV/AIDS has the potential to undermine the people's physical ability which varies between individuals as well as the stage of the illness. Therefore, although most PPLWHA in this study were physically active to engage in labour intensive activities, there are those who may find it difficult to participate in such activities due to health reasons such as in these cases:

> "The work I used to do was tedious ..... I am advised not to engage in labour intensive jobs" (Laone, aged 37).

> "My health condition does give me problems because I can't be engaged in any work at all, not even the household chores.... We are crowded in the few rooms that we have hence I started building the other room that I can't complete because of my health condition" (Lelentle, male aged 50).

These people are automatically excluded from the programme due to its nature of being labour intensive and therefore its lack of consideration of the HIV/AIDS and its impact on PPLWHA. UNDP (2002:10) has outlined key questions that need to be raised as poverty reduction strategies are developed and implemented. Some of these are relevant for

consideration for evaluation of the integrated poverty alleviation and housing scheme in Botswana. They are:

- How can the programmes be adjusted to the specific needs of households impacted by morbidity and adult mortality?
- Is targeting of the programme shifted so that it benefits those households falling below the poverty line as a result of HIV/AIDS?
- What policies and resources are required to ensure access to the programme for AIDS-affected households?
- How can the delivery of the programme better meet the specific needs of PPLWHA and affected households?

Incorporating these key questions into the programme has the potential to make it more inclusive of PPLWHA. However, as already indicated, the integrated poverty alleviation and housing scheme is a relatively new programme and any evaluation that is informative about it can only be achieved some time after implementation.

The Housing Officer (DoH) however acknowledged the limitations of the government in dealing with pro-poor projects and programmes saying:

> "Government do acknowledge that the Non Governmental Organisations (NGO) are better placed to deal with the low income and destitute groups of people more efficiently. They are better placed to know the potential of the vulnerable groups of people more than the governmental departments.... The current problem that we face is that the government is providing everything for the poor and vulnerable which makes them not to have ownership of any pro poor projects in place."

Thus when policy initiatives are transmitted in a top-down fashion they quite often take the form of directives rather than consultations, and this obviously does not allow for peoples' participation in formulation. People are, in fact, expected to become involved in the implementation process, whether they agree with it or not (Mwansa et al, 1998). This is the point at which policy may experience difficulty in being translated into reality. This top-down practice in the policy formulation process points to some degree of centralised governance (Schaefer & Lamm, 1995). Despite Botswana's democratic stance, the country continues with the top-down approach to policy. The failure of participation to empower people is partly attributable to the fact that, by and large, participation in the policy process and development occurs within hierarchical structures that tend to safeguard the status quo

and do not attempt to change and fundamentally restructure social relations. The next section outlines the participation of the NGOs in housing the urban poor in Botswana.

6.3 The Involvement of NGOs and the Private Sector in Housing PPLWHA

Given the democratic atmosphere that has prevailed in the country since independence it can be suggested that possibilities to influence policy and decision-making by civil society have always existed (Mwansa et al, 1998:69). The possibilities have actually materialised into substantial efforts to forge links between Non-Governmental Organisations (NGOs) and the government, so as to foster collaboration and partnership. The government realises that NGOs' contribution, quite often, demonstrates the extent to which the disadvantaged can be empowered. For a very long time, NGOs in Botswana have played an important role in alleviating the plight of the urban poor by re-inforcing governmental and community activities. As Mosha (1995) argues, there is however a lack of coordination and collaboration of the programmes and activities and as such sometimes there is duplication of effort. Among the many intervention programmes aimed at HIV/AIDS, there have been minimal efforts aimed at housing PPLWHA by the NGOs in Botswana. Habitat for Humanity Botswana has been so far the prominent NGO which helped the poor in general to acquire sanitary housing, besides the individual humanitarian efforts by civil society which are sporadic, not comprehensive, and also inadequate relative to the scale of need.

6.3.1 Habitat for Humanity Botswana (HFHB) and the Housing Needs of PPLWHA

The mandate of HFHB is to alleviate poverty housing needs in the low income group. The organisation fosters partnership with communities, individuals and private companies and the government in order to build decent, simple and affordable houses for low income people. HFHB has been the only NGO in the housing sector. The aims of HFHB are relevant and ideal to address the housing needs of the poor people and have embraced the needs of PPLWHA. Habitat for Humanity started its operation in Botswana in 1991 and it has been consistent in the provision of housing for the poor as highlighted below:

> "HFHB provides capital, building materials, training and co-workers while homeowner families provide sweat equity,[70] for the housing construction of the beneficiaries in

[70] Sweat Equity is a term used to describe the contribution made to a project by people who contribute their time and effort. In a model used by Habitat for Humanity, families who would otherwise be unable to purchase their own home (because their income level does not allow them to save for a down payment or qualify for an

> communities. The beneficiaries pay back a no interest mortgage over a period of up to six years. Habitat for Humanity does not enter a community unless invited and local committees made up of area leaders, potential homeowners and interested parties that help to manage the programme. These committees are responsible for overseeing the program including the selection of prospective homeowners, house designs, financial accountability and construction. Average HFH house in Botswana cost P18, 000 with an average monthly payment of P160. Because of homeowners' sweat equity construction costs are kept low."(HFHB Program Manager).

Besides housing the poor people, HBFB is engaged in housing initiatives that indicate that they have embraced HIV/AIDS into their programme and are responding to the housing needs of both PPLWHA and the affected families. For instance, HFHB are addressing the housing needs of the orphans as outlined by the Program Manager who said:

> "We have piloted housing for vulnerable children although at a very small scale and learnt a lesson from that hence our idea of designing a product tailored for Orphans and vulnerable children with the hope that it will bring positive change."

Furthermore, the housing programme does consider pertinent issues related to housing and the welfare of PPLWHA such as inheritance and security of tenure. For instance, the Program Manager said:

> "We have an agreement of sale; the contract we enter into with our beneficiaries. During the educational sessions with our beneficiaries we try and educate them on the issue of inheritance. We don't force them into it but we encourage them to always have somebody in the agreement of sale who can inherit the house in case the homeowner passes away.....we try to ensure that the homeowners' children do not lose the house at the end of the day."

Nevertheless, although the HFHB programme has proven to be comprehensive and successful in rural areas, its potential is not maximised in the country and is particularly not implemented in urban areas despite the critical housing need among the poor in Gaborone. This is due to limitations that seem common to most of the housing programmes including administration of urban land. Common to other housing programmes, HFHB experiences problems that hinder the programme from achieving its maximum potential of housing the poor in the country including shortage of land and affordability discussed in turn below.

---

interest-bearing mortgage offered by a financial institution) contribute many hours of sweat equity to the construction of their own home, the homes of other Habitat for Humanity partner families or by volunteering to assist the organization in other ways.

a. Administration of urban land

Despite the critical need for the services of HFHB in Gaborone, the shortage of residential land along with the governmental policies that govern urban land in Botswana have indirectly blocked HFHB's operation in urban areas. For instance, as already mentioned, urban land is unaffordable to the low income people and therefore most of them don't own urban land but do own land in rural areas where land is free of charge and hence it is easier for HFHB to help house rural households. Furthermore, the stringent measures attached to urban land development are too costly and would increase the price of housing construction for the HFHB house consequently defeating the main aim of the programme. Another underlying obstacle that prevents implementation of HFHB in urban areas is the illegal land transfers that are common among the poor in urban areas, particularly as some of PPLWHA indicated that they engage in such dealings when in desperate need for financial assistance. Regarding this issue, the HFHB Program Manager said:

> "...Illegal land dealings are more common in urban areas than in rural areas. This can work against our efforts and make our future as an organisation a bit uncertain... that makes it difficult for us to work with the urban communities."

b. Affordability problems

Similar to other housing programmes, HFHB is faced with affordability problems as highlighted by the Manager:

> "There can be too many cases that require write off...There are families that will be rendered poor and sometimes destitute due to many factors, for example, the loss of the person who was responsible for the housing costs. ....".

The HFHB is also faced with a problem of loan defaults which, as already discussed, is common among those with low income. However, unlike the SHHA programme, HFHB takes stern action against loan defaulters and this attracted political criticism as was highlighted in the local newspaper:

The Director of Habitat Botswana, said "they are taking action against defaulters who have no valid reason, especially those who have a regular income....because prior to building a house for someone, they educate beneficiaries on different issues, including possible actions in the event of defaulting."

However, although taking action against defaulters is something outlined and agreed upon between the two parties, politically it is seen as inappropriate as evidenced by a comment from one of the Political Activists who referred to this as 'an act of humiliation... a brutal act of aggression that must be condemned in the strongest terms.' But as the Housing Officer (GCC) commented, 'Politicians do things for their political interests'.

Despite the limitations faced, Habitat for Humanity presents a good model for providing housing for PPLWHA. However, none of PPLWHA in this study used the HFHB scheme primarily because the programme is not implemented either in Gaborone or peri-urban areas around Gaborone where PPLWHA in this study lived.

6.3.2 Botswana Housing Corporation (BHC) and the Housing Needs of PPLWHA

BHC was established by an Act of parliament in 1970 to meet housing needs of civil servants and the public at large as well as office and other building needs of the Botswana Government. To date the Corporation has developed to be one of the main residential housing providers in Botswana's urban areas through building houses both for rent and for sale. BHC is the primary provider of formal rental and sale of housing to low, middle and high income groups in Gaborone.

BHC provides good quality and sanitary housing with the necessary infrastructure that has the potential to support the health of PPLWHA. Theoretically its houses are inclusive and accessible to all income groups in Botswana and the low income are supposedly provided good quality accommodation through BHC low cost houses (which in theory should correspond with the income of the occupants). However, in reality, BHC houses are beyond the affordability of most of the low income people (Kerr and Kwele, 2000; Musyoki, 1998; Datta, 1995). PPLWHA highlighted that they are faced with problems including of high rental cost; discriminatory eligibility criteria; lack of priority on allocation criteria to vulnerable people of BHC houses and these have been discussed in detail in Chapter 5.

UNDP (2002) have stated that programmes tend to ignore the impact of HIV/AIDS on their products and don't consider it a priority hence they don't integrate it into their products. BHC has however identified and responded to some changes brought about by HIV/AIDS. For instance, it has responded to the issue of security of tenure which has

emerged as a problem in the phase of HIV/AIDS. The BHC Senior Estate Officer highlighted the Corporation had problems of security of tenure saying:

> "We have quite a number of tenants who died and that have created a problem in the sense that not only do they leave our properties with illegal tenants in them but we are faced with the problem where we have surviving relatives who fought over that property. It is a BHC property but because the kids have grown there and understand that it is their home, it becomes a problem when the main tenant whom we as BHC signed the agreement with has died. Because the relatives, as you know people in this society, they will always want to take over the house from the children, particularly when the children are still young. That creates a problem for us because as the organisation, we have to take the responsibility and act as a mediator in the situation of that nature."

BHC has since developed a policy that is aimed at protecting the security of tenure of the dependants of the tenancy holder. This was highlighted by the Senior Estate Officer who further said:

> "We (BHC) introduced the three year term agreement in 2003. One of the issues that we considered was that BHC will not be transferring any tenancy, to anybody outside the nuclear family. So we took that issue as a responsibility to make sure that people don't just come and claim other people's property.... there will normally be relatives and what BHC does is guard against this relative taking over the house. So, we require them (relatives) to take an oath (affidavit) to proof that the person is a legal guardian to the minors and is responsible for the rental, so even if we put the lease in their names, we know that it is a temporary arrangement and there is no how the guardian can later want to buy the property as a sitting tenant."

Issues of property grabbing have been reported to be widespread in some other countries[71] although in Botswana they have been speculative as already discussed in chapter 3.

Based on this observation, it can be concluded that BHC is stepping up some effort to ensure that their tenants have security of tenure. However, considering the extent of housing poverty highlighted by the PPLWHA, the effort made by BHC as the principal housing provider are arguably minimal and limited to those with the financial capacity to access BHC houses; the middle and high income people. The corporation has neglected the housing needs of the poor people and needs to do more to make their housing accessible and affordable to the poor in general and PPLWHA especially. As discussed in chapter 5,

[71] See Aliber etal (2004) on the impact of HIV/AIDS on land rights in Kenya where widows and orphans lost their property to relatives.

the cost of BHC houses coupled with the administration requirements[72] prohibits PPLWHA access to BHC houses.

The failure of the public and private housing organisation to satisfy the demand for housing of the poor people has led to a steady escalation in the demand for alternative forms of rental housing. People with moderate income resort to renting low priced accommodation in the informal housing market in Gaborone and this is discussed in the next section.

6.3.3 The Informal Rental Housing Market and the Housing Needs of the PPLWHA

Poverty alone, whether at household or national level, makes housing problems particularly difficult to deal with (Grimes, 1976) But, often the lack of realistic housing policies aimed at the poor worsens the situation. Botswana, like many other developing countries, has limited resources for the provision of housing for all the low income groups. The Botswana housing policy has been directing most of its resources towards encouraging home ownership through self-help housing in an environment of secure land tenure, flexible building codes, credit through building materials loans and provision of public utilities. Mooya and Cloete (2007:153), similarly to PPLWHA in this study, have observed that navigating the formal system may be difficult and too costly for most of the poor and therefore drive them into the informal housing sector. By concentrating effort on home ownership, the government and NGO programmes aimed at housing the poor have neglected those PPLWHA households that have affordability problems to buy or build. Because the cost of home ownership in Botswana is higher than the ability to pay, there was a need for a subsidy for the poor in general particularly those who are excluded from all the housing programmes hence have resorted to the informal housing sector. However the informal rental housing sector in Botswana is not without its own problems.

Precht (2005) argues that this neglect is two-fold: on the one hand, there is ignorance about landlords and tenants regarding their operating terms and housing conditions while on the other hand there is lack of concern on the government's side in informal rental issues. This is despite research showing the high prevalence of informal renting in Gaborone. Large numbers of low income households in Gaborone can only obtain accommodation as

[72] See Appendix 1: BHC Property Rental Requirements

tenants and subtenants in the SHHA houses. Datta (1996:241) reported that 58 per cent of SHHA occupants are not plot holders but tenants and sub-tenants. Although the Botswana government has committed itself to increasing the level of owner-occupation, the revelation that significant proportions of people are renting accommodation is clearly a challenge to the assumption that everyone wants to own. This therefore needs to be given greater consideration especially that the current rental housing market for the low income people is largely informal, uncontrolled and unregulated. This seriously jeopardises the market's ability to meet the shelter needs of the urban poor and to a larger extent exacerbates the problems associated with poor housing. Chapter 5 has highlighted that poor housing in the informal rented housing market is hurting rather than helping the health of PPLWHA especially. The lack of the necessary political will, recognition and support for this largest housing market that serves the needs of the urban poor implies that the market inevitably disregards the housing needs of the poor in general and PPLWHA in particular as discussed in chapter 5. The Housing Officer (DoH) confirmed this by saying,

> "Although we are aware of the renting problems, there is no legislation that controls renting in Botswana. Informal rentals are one area which people use as a livelihood strategy, and it has a big market .....We acknowledge that there are things that we as a department are going to fail to satisfy..... such as providing housing to each and every person who needs housing."

The informal rental housing market lacks control and regulation hence the tenants are left vulnerable in the situation. For instance, tenants have to pay high rents for low housing standards because there is no general framework for setting rent price and there is a lack of rent control in this section of the housing market. Despite that this is a long term problem in Botswana; the government has not been responsive on the issue (Datta 1995:4; Kerr and Kwele, 2000).The housing Officer (GCC) commented on the issue saying:

> "People price their properties haphazardly... there is no rent control in the national housing policy... anybody charges their own rentals. The rent charging is at the liberty of the landlords."

The government seems to have given the subsistence landlords power to exploit the poor coupled by the lack of tenancy agreements. Because this rented housing market lacks recognition and enforcement from the government authorities, landlords provide very little in terms of housing quality. However, as Datta (1995:4) argues, it is difficult for the government to interfere in this rental business as it depends on it for housing the poor people which it failed to provide accommodation for. On the other hand Malpass and

Dumba (2000) observed that this is a consequence of having the rented market that is nested within owner occupation. The intertwined market makes it difficult for the regulation of the informal market that is operated from the formal housing market, because the latter follow the regulations while the former can escape the building regulations as it is not recognised, controlled or regulated. The government needs to consider the rental housing for the poor more closely and devise some kind of policy for this housing sector which will not only provide a structure to regularise this housing market but also consider and accommodate the changes brought by HIV/AIDS in housing for the low income people.

6.4 SUMMARY

This chapter discussed the various housing programmes that are aimed at housing the poor in Gaborone. Particular reference was on analysis of how the housing providers have responded to HIV/AIDS and integrated it to their programmes to address the housing needs of the poor people living with HIV/AIDS in Gaborone especially.

The study outlined that SHHA is the major housing programme implemented by the government that is aimed at housing the poor people in Botswana. While the programme has the potential to meet the needs of the urban poor, it is faced with underlying problems including the shortage of serviced plots hence it has since been suspended despite the high demand and long waiting list; high building standards which are unaffordable to the beneficiaries; and the current tenure conversion which is unaffordable to the low income people hence the SHHA plot to remain in a tenure that cannot be used as collateral for mortgages. Of particular relation to PPLWHA is that SHHA loans are not insured hence increasing the potential of PPLWHA to loss of housing tenure in case of any eventuality that makes them lose the income and the ability to pay the loan.

Other government provided housing programmes include the newly implemented turnkey development scheme, which mainly provides a complete house to the qualifying beneficiaries. The programme has the potential to address the housing needs of PPLWHA especially those related to the housing quality. Although this is a current programme, since it is guided by the terms and conditions similar to those guiding the SHHA programme, it is inevitable that it will face similar problems such as affordability, accessibility and security of tenure. There is also the integrated poverty alleviation and housing scheme

which is aimed at catering for those not covered by either programme discussed but is more of poverty alleviation than a housing programme. Due to the fact that it is labour intensive, the programme has arguably overlooked the needs of PPLWHA whom research has shown that the disease has the potential to undermine their physical ability. On the other hand Habitat for Humanity which is the only significant Non-Governmental Organisation taking part in housing the poor, has helped the poor to acquire sanitary housing. However, the programme works more in the rural areas than in urban areas particularly due to the problems associated with urban land rights. Botswana Housing Corporation has been found to have neglected the housing needs of the poor and the low income although it theoretically has the houses that are for low income people. The cost of their houses and the administrative requirements make them inaccessible to poor people who resort to the informal rental housing market particularly in SHHA areas. Since the main aim of SHHA is to provide home ownership, it is difficult for the government to regulate and control the subsistence renting that has become popular in that neighbourhood. Consequently some of the landlords take advantage of the opportunity and overlook the housing needs of the tenants.

The data has highlighted that the housing providers in Gaborone have yet to integrate HIV/AIDS into their housing programmes hence address the housing needs of the PPLWHA.

6.5 CONCLUSION

The government of Botswana through the Department of Housing serves to address the housing needs of members of society; however there is the potential to do this more effectively than they currently do. Housing initiatives aimed to help poor people must take into account HIV/AIDS, particularly in a country that is among the hardest hit in the world. The recognition of housing as a key component in the fight against HIV/AIDS in Botswana should secure the necessary political will and fiscal support to enable the successful launch of sustainable housing programmes. If the government is concerned to address the housing needs of the population, housing should be made available in a form that will recognise and serve the needs of the diverse population including the PPLWHA. This will require the establishment of multi-sectoral and multi-departmental coordination and collaboration to ensure effective policy and its implementation. Currently, housing programmes are operated in isolation as various departments and organisations aimed at the same goal work

independently of each other thereby duplicating efforts and limiting the potential to address the housing needs of some key target groups such as PPLWHA, as stated in this narrative:

> "There are some housing programmes and projects scattered around the country. There is lack of coordination. For example, there is a destitute housing programme that is currently being implemented by the Department of Social Services. If the programme is implemented by another department in a different Ministry, we don't have any contribution to it." (Housing Officer, DoH).

However, a national housing policy and strategy has to adopt a multi-faceted approach towards serving all segments of the housing market with particular emphasis on the vulnerable groups of people including PPLWHA. As King (2003:96) argues, housing policies should not benefit some individuals at the expense of others and should be able to deal with the vulnerable people without generalising vulnerability, something that the Department of Housing seems to be doing as the Housing Officer (DoH) highlighted,

> "Subsidies for poor people are inclusive of all people and don't segregate according to any kind of need. We have the SHHA programme for low income people and they all pay a subsidised price for their plots."

The government of Botswana is currently focused more on home ownership. However, King (2003:25) argues that owner occupation has been idealised as offering choice and personal responsibility and thus reducing dependence on the government. But, home ownership is limited by a multiplicity of factors such as income, employment, family circumstances, planning constraints, and supply and demand. Given the skewed income profile of the Botswana population and the severe affordability problems at the lower end of the market, there is a need to consider programs that have a balance of end-user affordability and the housing options provided. This implies considering non-ownership options of housing the low income people. NGO's have played and are playing a significant role in supplementing and building capacity at community level. It is believed that these organisations have a very important role to play in this respect and the government acknowledges that they are,

> '...Better placed to handle the pro poor projects than the government'.
>
> Housing Officer (DoH)

For some PPLWHA households access to housing initiatives and programmes at a level matching means at their disposal is not available in the formal housing market, so they are housed in the informal housing sector. The more limited the ability of these households to

partake in formal housing initiatives, the more the responsibility on the government to support the endeavours of such a household to house themselves. However there is still lack of a comprehensive document that directs the activities of the informal rental housing market. Given the high levels of HIV/AIDS and poverty (which are closely related) in Botswana and the extent of participation of the affected people in the informal rental housing market, the question that remains to be answered is why the Botswana government has a closed eye to this market that could be explored to address the housing needs of the majority of the urban poor.

The government, non-governmental and private sector need to collaborate and take up the challenge of meeting the needs of PPLWHA more essentially. The housing process needs concerted efforts that are fiscally, socially, financially and politically supported for it to be sustainable in the long term. But as the former Principal Housing Officer (GCC) observed,

> "....for the collaboration, people need to understand the housing issues.....The stakeholders must understand the relationship between housing and HIV/AIDS. ...Housing issues are considered in isolation and that will not work effectively. The policy makers, the politicians need to understand the housing issues on the ground in order to address the issues accordingly.....In order to change, there is a need to understand why you are changing. For those who understand housing issues, they can make recommendations on what need to be changed. Unless people are convinced and understand the need to change, they will not welcome the change."

The government needs an understanding of the vital role of housing in the promotion of health and improvement in the quality of life of PLWHA. The collaboration and coordination of agencies focused on housing is very important as it could help in advocating and promoting housing for PPLWHA. The next chapter is the conclusion of this study and will highlight the key issues raised as well as make recommendations for policy and future research.

CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

This concluding chapter draws together the key research findings of this thesis, their implications as well as the contribution made in terms of knowledge and theory. The chapter proceeds to identify future investigations that have been stimulated by this research work.

The rationale of this study is that a study of this nature has not been done in Botswana. As demonstrated in the literature review most work on housing and health, particularly studies emphasising housing problems faced by the poor people living with HIV/AIDS originate from developed countries.

Box 1: Key Research Questions

Research question one: What are the socio-economic, environmental, and physical and health problems and difficulties experienced by the poor people living with HIV/AIDS in their housing in Gaborone?

Research question two: How do the poor people living with HIV/AIDS respond at personal level in an endeavour to cope with their housing problems and difficulties?

Research question three: What underlying factors and/or structures are apparent to the different housing stakeholders; hence having an influence in the response to the housing problems and difficulties faced by PPLWHA?

Research question four: What intervention strategies have the lands and housing policy makers and other housing stakeholders put in place in response to lands and housing problems and difficulties faced by poor people living with HIV/AIDS?

Chapter 4 has outlined that through adopting the in-depth interviews and using the critical realism theoretical approach, it has been possible for this study to be able to gain insight, answers and explanations to address the four key research questions outlined in Box 1. Unlike using other scientific approaches which search for statistical correlation among

multiple cases, critical realism was used not only to acknowledge the existence of socially constructed experiences such as multiple meanings and interpretations of structures such as poverty and HIV/AIDS. But also to look deeper into underlying actual physical and non-physical conditions, actual events and influential social relations (such as customary norms and cultural practices, gender inequalities, land and housing tenure security, socio economic issues and the access to the housing market).

This section will return to this study's key research questions to explain how they have been addressed and answered in this study. However it is important to note that the research questions in this have been collapsed together because researching social life is complex particularly as it deals with human beings who learn their behaviours from their own experiences and cultures and comprise overlapping domains of experiences, events and conditions.

7.2 Addressing the Key Research Questions

This section is sub-divided into three sub-headings aimed to outline the key findings of the study section in relation to the study's main research questions outlined in Box 1. Section 7.2.1 is twofold, on one hand it focuses on research question 1 by summarising the key problems that have been reported by PPLWHA which hinder them access to sanitary housing. On the other hand it brings in research question 3 by considering the underlying dynamic structures, condition and agencies that may have an influence and consequently contribute to the problems. Section 7.2.2 focuses on research question 2 by giving a summary and conclusions of how the housing problems faced by the PPLWHA exacerbate their HIV/AIDS problem through evaluating the formal and informal strategies that PPLWHA adopt in an endeavour to deal with their housing problems, as discussed in chapters 2 and 5. This leads to section 7.2.3 which addresses research question 4 through considering the institutional interventions and role of the state in addressing the problems, discussed in chapters 3 and 6.

7.2.1 Key Problem and Underlying Structures that Hinder PPLWHA Access to Sanitary Housing in Gaborone

Guided by critical realism theory, this thesis has shown in chapter 5 that PPLWHA are faced with a variety of housing problems and most PPLWHA have an immediate need for housing assistance. While the study outlined poverty and HIV/AIDS as the major

contributing factors to the housing problems faced by PPLWHA, there are other underlying structures such as: economic structures including unemployment, lack of housing finance for low income and the poor; political structures such as stringent building codes and control; and social structures such as cultural norms and traditional beliefs and gender inequality interconnected with HIV/AIDS and poverty which exacerbate housing problems of PPLWHA. This thesis has argued that poor people living with HIV/AIDS are the most vulnerable group that faces difficulties in coping with the effects of the epidemic, primarily due to poverty-related problems including affordability problems and lack of access to resources at both household and national level. PPLWHA as a result experience the effects of a powerful intersection of poverty, stigma, poor housing and illness. This is in tune with what Lawson (2006) posits:

> 'Real risks are concentrated among those households with fewer and less secure monetary resources.'

The effects of the HIV/AIDS epidemic were found to be the reduction of disposable household income, consequently pushing some of the non-poor people into poverty and deepening poverty for the already poor households. Poor women have been especially identified in this thesis as the hardest hit group in terms of vulnerability to HIV/AIDS infection as well as the effects of the epidemic due to their social, economic and legal disadvantages (Collins and Rau, 2000:19). The problems faced by poor women living with HIV/AIDS have been found to be further exacerbated by a variety of cultural beliefs and norms widely practiced in African societies which are mostly to the disadvantage of women. For instance, the study has outlined how cultural norms at household level contribute to problems such as gender inequality by making poor women subordinate to their male counterparts. Culturally males are expected to provide the basic needs, including the provision of housing for their households. While this present study is largely informed by women (25 women and only one man), it is important to recognise that the housing problems faced by PPLWHA are to a larger extent gender neutral and therefore any response to housing insecurity related to HIV/AIDS must take men on board.

Although housing has been identified as an instrumental need (King, 2003:30), the study indicated that while the medical and social needs of PPLWHA have been greatly supported by the government, the efforts to address the housing needs of the PPLWHA have been sidelined. Consequently, housing remains the main unmet but essential need faced by the

PPLWHA in Gaborone. This discrepancy is due to the fact that although in Chapter 2 the literature review outlined that in developed countries housing is treated as a social determinant of health, generally in Botswana housing is not yet connected to health, particularly as a means that could be beneficial in the control and management of HIV/AIDS (Ranson, 1991; Aidala, 2000; Dunn, 2002; CAMH, 2007). This study indicated that the fundamental problem for PPLWHA in Gaborone is the critical shortage of safe, affordable and appropriate housing that could be used to mitigate the effects of HIV/AIDS on the poor. The study revealed that while this research has to some extent some influence from the feminist theories concerned with the power of culture to construct social identities, such as gender, and to empower or marginalise and silence certain sections of the society such as the poor, the problems faced by PPLWHA go beyond that, hence adopting the critical realism theory. By taking the epistemological position influenced by critical realism, it becomes possible to acknowledge and recognise a combination of structures, mechanisms and events co- determining the problems faced by PPLWHA. Based on critical realism theory, the study categorised the housing problems faced by PPLWHA into three domains explained in Figure 7.1 as follows:

The real, which consists of process, structures, powers and causal mechanisms that generate events;

The actual, which relates to activation of events which may be either observable or non-observable and consist of underlying mechanisms or structures, which tends to have influence in favourable circumstances;

The empirical involves experiences and events through observation and giving the opportunity to explain any observable effects with reference to the underlying unobservable structures

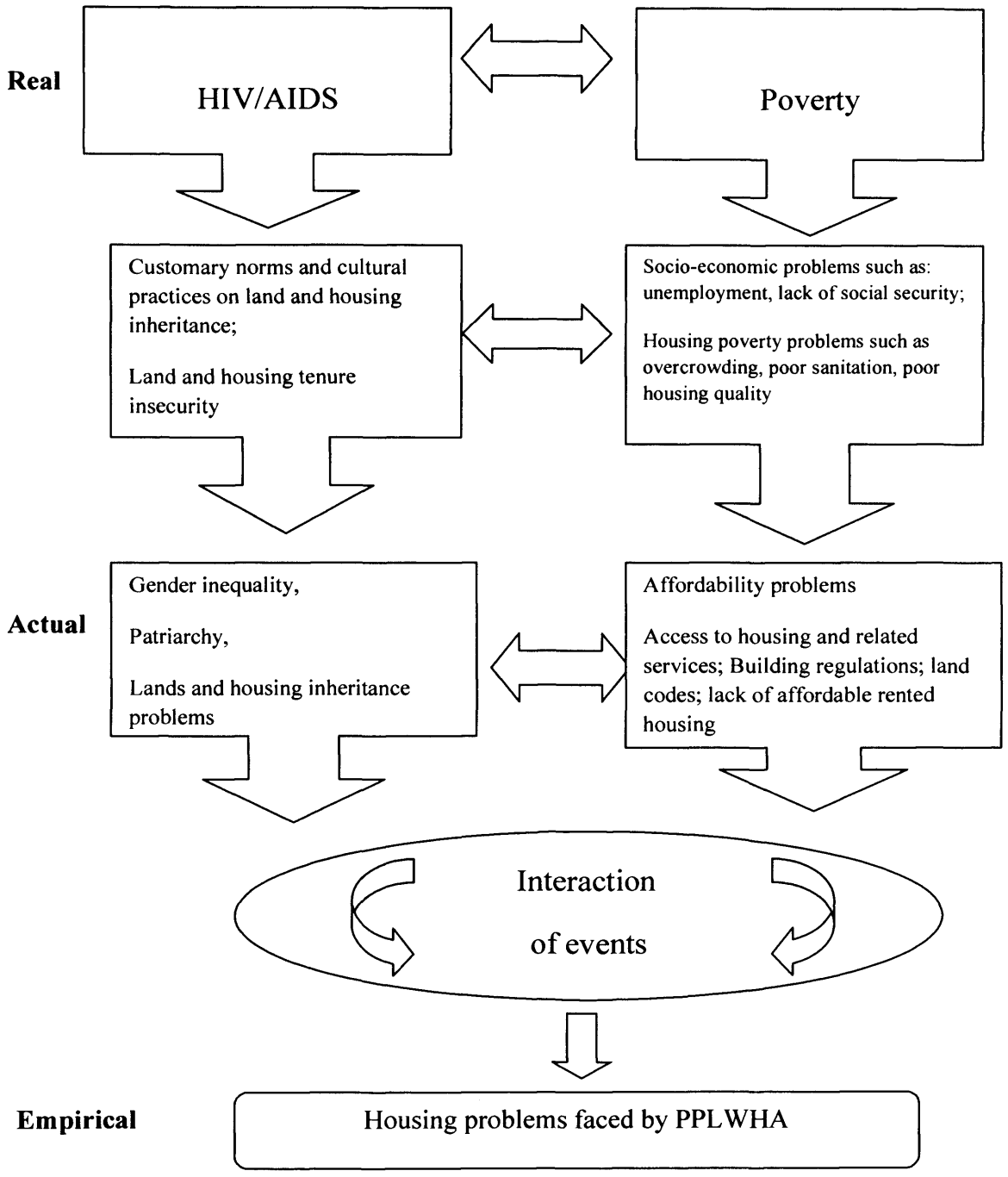

Figure 7.1: Framework for explanation of housing problems faced by PPLWHA

Poverty and HIV/AIDS represented the 'real domain' of critical realism theory, as they were perceived to be the main observable structures that are primary to the housing problems faced by PPLWHA although as CAHM (2007:54) posit, 'the poverty is often a worse trauma than the HIV/AIDS'. The poverty experienced by PPLWHA was found to be

exacerbated by socio-economic issues including high rate of unemployment, low incomes and the lack of a comprehensive social security system designed to cushion people against declining income in the country.

The study revealed that the housing problems faced by PPLWHA are not due to one single factor but are rather an outcome of an intersection of several factors including those directly related to provision of land and housing for the urban poor in Botswana. Underlying the housing problems faced by PPLWHA, there are various issues related to the general housing market which include: building regulation and control, security of land and housing tenure, access to and affordability of housing properties, housing finance and housing related services, which emerged unaffordable to the poor.

These hindrances coupled with the underlying issues of poverty faced by PPLWHA place them in precarious housing conditions particularly common in informal housing within site and service schemes which poses a further risk to their already compromised health. In the precarious housing conditions inhabited by PPLWHA, there are high rates of overcrowding and serious lack of access to good sanitation. Opportunistic infections and enteric diseases related to HIV thrive in these conditions and put the health of PPLWHA under further threat. These poor living conditions undermine the safety, privacy and efforts to promote self respect and human dignity for PPLWHA. This study argues that addressing the health needs of the PPLWHA without correcting the fundamental infrastructure availed for the PPLWHA is an impediment that undermines the effectiveness of pertaining health programs and therefore hinders the desired change and proposed outcomes. While Botswana is striving to control HIV/AIDS and has embarked on the free administration of ART to PPLWHA, it is necessary to equally address the housing needs of PPLWHA. Housing forms the integral part that links poverty, inequality and HIV/AIDS risk and outcomes of infection. Consequently sidelining it in the process defeats the purpose of other HIV- related strategies.

However, emphasising the housing problems faced by PPLWHA without taking into account other groups of poor people and households that are not directly affected by HIV/AIDS has been a limitation in this study. There is a need to establish whether the land and housing problems experienced by PPLWHA were in fact unique to those households directly affected by HIV/AIDS or affect the poor people in general even in the absence of

HIV/AIDS. However, consistent with what Aliber etal (2004) observed, HIV/AIDS arguably makes the problems more prominent for the PPLWHA.

7.2.2 Responding to the Housing Problems by PPLWHA

The study revealed that the lack of affordable housing in Gaborone exposes PPLWHA to situations that directly impact on their health. It also hinders the ability to reduce the health risks, particularly the risky behaviours that have the potential to spread HIV/AIDS as well as intensify the disease for those who are already infected. PPLWHA who find it difficult to access and afford housing in the open market resort to living in rented multipurpose rooms within a shared plot; in their parental homes; or move in with their boyfriends and/or male partners, all of which are done with the primary aim of reducing the housing costs. The study found that most PPLWHA lived in shared plots within a shared single room which is not only shared by several people but also used for sleeping purposes and other domestic activities. Room and plot sharing was found to be common among PPLWHA despite the increased potential sharing has on contributing to the problem of overcrowding and poor sanitation. Consequently this produces poor living conditions which worsen the health risk for both PPLWHA and the people sharing the various spaces through provision of a fertile environment for transmission of communicable and enteric diseases associated with HIV/AIDS such as tuberculosis and skin diseases. The problem of overcrowded shared rooms was not only common in rented rooms but was also in family homes and owner occupied houses.

The study also found that in responding to the housing affordability problems, some of PPLWHA adopted the desperate measures which consequently compromised their health. Some women were found to have moved in with their male partners and boyfriends in an attempt to cope with housing costs. In so doing, housing affordability can affect economic deprivation and worsen gender inequality for women in particular, because some PPLWHA who are faced with affordability problems were found to be engaged in 'relationships' with the main aim of getting assistance with housing and related costs. This finding is consistent with what is reported in the literature from elsewhere. Surratt, (2004) quoted by Weir et al (2007) has indicated that 'some individuals in unaffordable housing may trade sex for money in order to pay for their accommodation'. Although in this study, the practice of sex trade by PPLWHA was neither directly reported nor observed, the number of PPLWHA who lived with boyfriends and those who reported to be getting

financial support from boyfriends primarily to cater for the housing costs gave an insight that lack of housing may contribute to the dependence of female on male partners for meeting their shelter needs. In the age of HIV/AIDS, this dependence on male partners has the potential to increase the gender inequalities which limit women's control over the circumstances in which sexual intercourse occurs hence lowers the risk of transmission and increase the chances of re-infection for those already infected as well as limit their ability to protect themselves against HIV/AIDS for those who are not yet infected.

The study has outlined that while poverty coupled with HIV/AIDS poses an increased potential of PPLWHAs' vulnerability to loss of undeveloped residential land, there are underlying factors that particularly heighten the problem for PPLWHA. Land codes in Botswana specify that undeveloped land reverts to the allocation authority after a specified number of years. Although these land codes pose a risk to loss of land tenure on all people who fail to develop their allocated plots within the given time, PPLWHA have an increased risk due to their weakened economic ability. The high costs of housing development in Botswana, coupled with the lack of housing finance suitable and affordable for the poor and low income people exacerbate the problem. In response to loss of land tenure, the study has revealed that PPLWHA resort to selling their land rights hence they remain landless and lose the future inheritance of their children. Whilst literature from elsewhere reported that in some patriarchal societies, widows and orphans are often faced with the problem of land grabbing by male relatives upon the death of husband/father, the problem has not been evidenced in this study. However, as Drimie (2002), the stigma attached to HIV/AIDS fosters a culture of silence which may prevent obtaining reliable data on HIV/AIDS and related problems.

7.2.3 Housing Providers' Responses to the Housing Problems Faced by PPLWHHA

The study revealed that housing should be seen as a multifaceted issue that has many related factors. Understanding this, housing practitioners and policy makers cannot look solely at individual conditions in determining the housing need. In order to address health disparities including HIV/AIDS, it is imperative to address key social determinants of health such as housing. Literature surveyed in chapter 2 of this study outlined that having improved, safe and sanitary housing has been found to have the potential to reduce the risks associated with HIV/AIDS, improved access to medical care and better health

outcomes (Lozier, 2006; Aidala et al, 2005). People in poor housing conditions as well as those in desperate housing need such as some PPLWHA in this study have lifestyles that place them in situation that make it difficult for them to manage their HIV status such as living in overcrowded housing, sharing pit latrines with many other people hence the potential for spread of contagious diseases and infections. This study has revealed as countries reform their housing policies to integrate HIV/AIDS, Botswana is still lagging behind in that respect. Botswana is yet to appreciate and embrace the notion of housing, health and improved welfare and hence accommodate HIV/AIDS into its housing policy, housing programs' projects and initiatives. The study contends that for the country that has an alarming proportion of PPLWHA in its population, it is impracticable to have a housing policy that does not address the problem of HIV/AIDS.

The findings of this study in chapter 6 showed that the government of Botswana does endeavour to address the housing needs of the general urban poor population as evidenced by the several housing programmes and initiatives put in place for this purpose. However, what is missing is that the current housing programmes and initiatives outlined in the national housing policy have been unable to recognise the importance of housing in the PPLWHAs' health and wellbeing and thus have not adequately integrated HIV/AIDS into their housing strategy. A clear example of this oversight, which is also of great significance in this current study, is that the Self Help Housing Agency (SHHA), which is the main housing scheme designed to house the poor people, provides uninsured housing loans. This places the PPLWHA at a greater risk of loss of property through repossession should they fail to make loan repayments due to loss of income caused by their ill health. As argued elsewhere in this study, the sole housing programme (Integrated Poverty Alleviation and Housing Scheme) aimed at poverty alleviation can be an effectual programme to address the housing needs of PPLWHA, but it is labour intensive. Consequently it discriminates against PPLWHA as they find it difficult to partake in this programme due to their ill-health. This study therefore suggests that for the government to address the housing needs of the population, housing and related services should be made available in a form that will recognise and serve the needs of the diverse population including the PPLWHA.

This study has shown that the participation of non-governmental organisations aimed at housing the urban poor has been found to be very limited to only one organisation in Botswana despite the idea that NGO's are better placed to address the pro-poor projects

more effectively than the government. Furthermore, housing programs with similar goals and aimed at similar groups of people operate in isolation and independent of each other. By so doing, they duplicate efforts and hence reduce the potential to address the housing needs of some key target populations such as PPLWHA. What is missing is the coordination and collaboration between the housing providers, the political will to direct the efforts to where needed most and the fiscal support to launch sustainable housing programmes. Osei- Hwedie (2004) emphasised that for the organisations to focus on and support the fight against poverty and related social problems, it requires effective cooperation and collaboration between the government, civil society and the private sector.

The crucial issue raised in this study is that the informal housing market that operates within the formal housing sector (primarily in SHHA areas) has filled the gap by catering for the neglected housing needs of the urban poor. The study in chapter 6 revealed that the housing department is aware of the crucial role played by the informal housing sector and the potential it has in addressing the housing needs of the urban poor. The lack of government support for the endeavours of the public in housing themselves through taking responsibility is a failure on the housing policy side. This puts the poor people at risk of exploitation as the informal housing sector lacks a comprehensive document that directs its activities; nevertheless the informal market is accidentally useful to PPLWHA who would otherwise not be able to compete in the formal housing market. All that is required is for the policy makers to provide the necessary conditions that can facilitate the most effective way of using the informal housing market development.

Furthermore, the study found that underlying the housing problems faced by PPLWHA in urban areas in Botswana, there are many contributing issues. These include high housing costs coupled with the implementation of rigorous housing standards which are unaffordable for PPLWHA. The current costs of infrastructure and associated costs related to building regulations, codes, standards and procedures are inappropriate and prohibitive to the housing requirements of the low-income population particularly as there is a lack of housing subsidies which can be used to cushion the housing costs for the vulnerable households such as PPLWHA.

The lack of housing finance available in the form appropriate for the poor people was revealed as a contributing factor to the housing problems of PPLWHA. The conventional housing finance providers are inaccessible and their funds certainly not affordable to the

poor people due to the requirements and conditions that discriminate against the poor in general and the PPLWHA who are mostly faced with financial difficulties already.

7.3 Limitations of the Study

There are three main areas of the methodology that should be given particular consideration in this study. The first is the ethical and access issues surrounding research on people living with HIV/AIDS; the second is recruiting male participants into the sample of PPLWHA; the third is the limitation of translation of data in which the interviews were planned in English, conducted in Setswana, translated back into English for transcription and writing up.

7.3.1 Access and ethical implications for the study

HIV/AIDS is a sensitive topic; therefore interviewing PLWHA inevitably raises ethical concerns. Studying people living with HIV/AIDS is naturally sensitive, personal and has a degree of controversy due to the stigma and discrimination attached to the disease.

The process of access negotiation in this study was not only a daunting task but also a potentially illegal act in Botswana because 'labelling' a person 'HIV positive' without their informed consent and/or evidence from a medical report may be considered as stigmatization, as inhuman and degrading treatment (Ndadi, 2008). Therefore doing research with PPLWHA in Botswana requires the researcher to be more careful especially in recruiting PPLWHA to participate in the study.

The process of negotiating access to interview PPLWHA was a challenge mainly because of the research fatigue apparent on the PPLWHA and as a result that the researched wanted to be rewarded for their participation. This research fatigue contributed to the reluctance to participate which was experienced at the beginning of the process. However PPLWHA became increasingly open to the researcher after building the necessary trust and offering reciprocity in a form of pecuniary (cash) incentive to participate in the study. Since the cash incentive was not budgeted for, it constrained the finances available for the study. Future research with PPLWHA therefore needs to integrate pecuniary incentives. The study revealed that doing research with PPLWHA requires that the researcher approach the matter more carefully and build a considerable degree of trust with the researched to be

able to yield valuable data. As Silverman (2005) noted, the impression the researcher gives to the researched may be very important in granting access.

Nevertheless during the interviews some PPLWHA became distressed (partially because they may have not discussed their experiences with other people before). Researchers interviewing PLWHA therefore need to be cautious that they don't end the interview before PLWHA calms down. In some instances it may even be necessary for the researcher to make follow-up visits to observe how PPLWHA are doing and refer them for relevant help as some issues discussed in the interview could have triggered feelings that could create problems for the respondents after the interview.

In-depth interviews proved to be a valuable way of framing the current study because; on the one hand the interviews have been a way of empowering the poor people living with HIV/AIDS by giving them an opportunity to voice their housing experiences and to outline their housing needs. On the other hand, it gave the researcher the opportunity to relate more closely to PPLWHA and achieve what could have been difficult to be achieved through using quantitative data collection methods. While this was a good experience, it is inadequate. Future research should integrate the use of the observation method in order to have an insight of how PPLWHA use both the outdoor and indoor housing space beyond the descriptions made during the interview. This will help the research to have a visual and clearer picture of the housing problems especially those related to the physical housing structures. Although engaging in such research could have resource implications, it would benefit the quality of data greatly and lead to better recommendations and contributions to the subject area.

7.3.2 Recruiting Men Living With HIV/AIDS into the Study

Due to the sampling procedures, this study is largely informed by women: 25 female and only one male participant. Anecdotal evidence indicates that often cultural beliefs and expectations of manhood or masculinity discourage male involvement and participation in activities and matters related to sexual health including issues related to HIV/AIDS. It is important to recognise that the housing problems faced by PPLWHA are to an extent gender neutral. Therefore the participation of men living with HIV/AIDS could have provided this study with the male view of the problem and hence contribute to the potential to make informed decisions when addressing the problem and ultimately creating an

enabling environment for change. To improve male involvement in studies such as this one, there is a need to adopt gender sensitive strategies that take cultural norms into consideration without promoting gender inequalities. For instance, the researcher may need to engage a male to recruit and address male participants as they may feel comfortable to discuss issues with someone of the same gender.

7.3.3 Translating Data

Undertaking qualitative research in a non-English language and translating the data back to English emerged to be not only a complex and time-consuming process but had an increased potential of compromising the quality of the data. Interview data collected in Setswana and translated into the English language needed to be translated carefully and in such a way that the meaning of the data is understood clearly and not compromised during the translation process. Translating words which help to describe concepts and experiences for which there is no true equivalent within the source language emerged as a difficulty in this study. During the translation process, the researcher identified that not all concepts were universal and therefore not everything was translatable hence some meanings may have been partially lost in the process if an equivalent word was not found and personal interpretation invoked. The study acknowledges that whilst translation is still a problem in the same language, having to translate data between languages made it more difficult. It was therefore important that the translator is careful and remains as close to the original meaning of words, expressions and connotations as possible in order to produce translated transcripts which are comprehensible and to increase their reliability.

7.4 Recommendations

The recommendations in this study fall into two main categories; namely policy issues and research issues. The former address some significant policy factors that may be useful in future housing and HIV/AIDS research; the latter identifies areas requiring further research in view of the study's limitation and the issues this study has raised.

7.4.1 Policy Implications

This study reported that PPLWHA need improved, cleaner, safer and affordable housing with improved sanitation systems. Improvements in housing can contribute to the control of communicable diseases related to HIV/AIDS. The study revealed that while there are

medications that extend and enhance the lives of PPLWHA, effectively addressing HIV risks and associated problems requires attention to structural determinants that directly and indirectly affect the individual's ability to avoid exposure to HIV risk. Housing has been identified to form the locus for participation in the support, rehabilitation and treatment that ultimately have the potential to lead to a better health outcome and lower the cost of HIV/AIDS treatment for the government. Unless deliberate and proactive interventions are put in place, current problems in housing and health will intensify rather than reduce. If the government is concerned with addressing the housing needs of the poor people living with HIV/AIDS, housing should be viewed as a service made available in the form of a broader welfare issue intended to serve the multiple and simultaneous needs of the poor and PPLWHA. HIV/AIDS prevention and care strategies will not succeed without addressing the structural barriers such as housing instability.

There is a need for a paradigm shift in the delivery of housing in Botswana – to view housing as core within the HIV/AIDS intervention strategies. The housing situation for PPLWHA in Botswana requires a national housing strategy to embrace the following key aspects:

- There is an urgent need to recognise that housing affects not only the health but other social determinants of health such as poverty. It is therefore imperative to acknowledge and understand the potential housing has as a key component of the HIV intervention plans for PPLWHA. Housing PPLWHA needs to be understood as a sound health care investment. The provision of housing and services must be in the forefront of the housing policy discussions. With limited direction and resources from the government, other housing providers have difficulty providing both housing and related services for PPLWHA.

- Support for housing initiatives aimed at housing PPLWHA is fundamental. The study outlined that there is separation among housing providers and between housing and HIV medical providers. There is a lack of cooperation and collaboration among the housing and housing related organs in Botswana. The knitting together of various departments which attempt to solve a problem of mutual concern is an important and long overdue step forward in housing. Individual, fragmented and isolated efforts cannot achieve the goal of ensuring access to affordable and healthy housing because the housing issues for PPLWHA

involve a multidisciplinary network. A combined understanding represents a valuable local resource which can be channelled into making housing more balanced, more inclusive, and more effective. The government through the Department of Housing needs to take the central lead and provide the environment that supports the collaboration and partnership of the departments and organisations that seek to address the housing needs of the poor.

- In spite of ample evidence regarding presence and problems of the informal rented housing market in Gaborone, the government is not seriously addressing the issue. While the current conditions that prevail in the informal rental housing market are not conducive to the health of PPLWHA, they could be improved and emerge beneficial. There is need for the government to acknowledge and understand the dynamics of the informal rental housing market and consider regulating and supporting it in order to maximise the potential it has in the provision of housing for the urban poor.

- Since conventional housing finance does not reach the urban poor in Botswana adequately, there is a need to mobilise innovative financial support aimed primarily at housing for the poor and vulnerable groups of people such as PPLWHA. There is a need to explore strategies that promote appropriate means to provide housing finance that is accessible and affordable for the poorer sections of the society. Provision of housing finance could encourage the poor to develop quality housing as well as to maintain, repair and improve the quality of the housing that already exists. The notion of housing microfinance initiatives needs to be explored in Botswana as they are increasingly being adopted successfully in other countries and prove beneficial in addressing the housing needs of the urban poor.

- There is a need for the government to invest in affordable housing with the primary aim of meeting the housing needs of the poor in general and PPLWHA especially. As Bryant (2003:53) asserts, social housing reflects a commitment by the government to supporting affordable housing for the vulnerable groups of people in a population. The study revealed that the Botswana housing policy have focused on homeownership as an ultimate housing solution, an option that is outside the affordability for many PPLWHA. Important to notice by the housing policy makers is that the housing policy that focuses on getting people into homeownership needs

to consider other problems that the people may face that may jeopardise their housing stability such as HIV/AIDS. As such housing policy makers need to recognise that housing must be connected to other services such as affordable housing insurance.

7.4.2 Issues for Further Research

The field of HIV/AIDS and housing although an issue that has been recognised since the initial cases of AIDS in the Unites States (Aidala et al, 2005), the issue is largely unexplored and has much potential for exploration in the context of Botswana. This current research took a step to explore the underlying structures and conditions that contribute to the housing problems faced by PPLWHA hence providing useful insights into housing problems faced by PPLWHA in Gaborone. Even with these findings, there are areas in which future research work can be carried out to develop the knowledge further. There is a need to carry out a housing needs assessment that could be used to explore further the relationship between housing, poverty and HIV/AIDS while outlining the housing needs of PPLWHA in the context of Botswana. Such research could be used to distil the unique effects of housing conditions from other potential variables that may influence health especially for PPLWHA. The research could seek to address the following key questions:

1. Are the housing challenges unique to PPLWHA, people with chronic diseases, the urban poor or do they affect the general poor population in Botswana? This study has touched the surface of the many potential underlying problems that may be contributing to the problems faced by PPLWHA. There is great need to be explored and to understand further how these underlying factors relate to one another and work collectively to influence the housing needs of PPLWHA. While this study provides compelling support for the provision of housing as a key structural intervention strategy to managing HIV and to improve the health of very low income persons living with HIV/AIDS, rigorous ongoing study is required in order to better understand how the intervention operates and how it can be most effective. Such research will deepen the understanding of the impact and effectiveness of housing as a structural intervention.

2. Are the housing problems faced by PPLWHA primarily a consequence of the nation's broader housing issues, including financial credit? The empirical findings

on this research point towards the need for a shift in housing research model in Botswana - one that looks to explore not only the condition of the physical housing structure of the poor people but that search for underlying generative causes and structures based on the critical realism theory. If successful, these models can be replicated to address housing for the poor in general as well as in exploring the housing needs for the population with other chronic health illnesses besides HIV/AIDS.

3. How can housing and related services be best utilised to play a significant role that can be beneficial in the system of HIV care within the context of Botswana? Housing for PPLWHA needs a clear vision; unfortunately empirical evidence in this study revealed that there is no clear policy direction for any of the areas related to housing and HIV/AIDS in Botswana. As a consequence housing providers receive inadequate and poor directions for housing and myriad conditions that adversely impact PPLWHA. This gap needs to be empirically explored. As one of the former housing Officers indicated in this study:

> "Housing (Department) really needs to look into the issue of HIV/AIDS much more closely by undertaking a study to find out what kind of issues are on the ground before they can respond to the problems. That is when they can formulate strategies on how to deal with the problems identified. From my personal knowledge, I don't think there has been any policy direction on HIV/AIDS and housing. It is always mentioned on public speeches, it is acknowledged as a challenge. But there is no official response to the challenge from the housing perspective" (Former Housing Officer, DoH)

4. What strategic steps can be adopted to develop, expand and strengthen the access and affordability of sustainable housing and related services which have the potential to improve the lives of PPLWHA?

The empirical findings of this study revealed that PPLWHA as well as the poor in general are deprived of the financial services of conventional banks particularly based on collateral hence they find it difficult to develop their housing. There is a need to explore housing micro-finance models such as the one used by the Grameen Bank (Discussed in section 3.5.3 of this study) which extend banking facilities and administer collateral free micro -credit to the poor. Such a model has been proven successful in other countries such as in Bangladesh and may be suitable in the Botswana context if explored and adopted. Additionally such

financial efforts would be especially beneficial not only as a credit provider also as an empowerment to PPLWHA and the poor in general in helping them better their livelihood and eventually their communities. As the Housing Officer in the Department of Housing said during the interview for this study:

> "With the active involvement of government in housing provision, people might tend to relax and depend on government for provision without having any social responsibility towards their housing. ...vulnerable people are not helpless, hopeless people, they have the potential which need to be explored but they don't have the resources. The NGO's coming with the resources and the expertise, bringing it together with the unexploited potential that the vulnerable people have, they could be great results from the pair." (Former Housing Officer, DoH)

This study has concluded that the lack of adequate housing must be addressed as a barrier to effective HIV prevention, management and care. If Botswana is to tackle the spread and treatment of HIV and AIDS in the society, we absolutely must address the need for stable housing for people with HIV and AIDS. Housing is not a luxury; it's a necessity. With stable and safe housing comes better health and healthier habits, especially for those living with HIV/AIDS. This study argues that there is a need to expand access to safe and affordable housing for the urban poor people living with HIV/AIDS in Botswana. This is in line with the statements by The International Declaration on Poverty, Housing Instability and HIV/AIDS.

> "Everyone has the right to a standard of living adequate for the health and well being of him [or her] self and of his [or her] family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his [or her] control."
>
> - *Article 25, the Universal Declaration of Human Rights*

Such a discussion links the findings of this study to the current policy issues facing housing and HIV/AIDS. By so doing it is hoped that this study's findings can help influence some of the structural issues that make delivery and provision of housing for PPLWHA as well as those trying to serve them. This study provides a starting point for analyses of the housing problems faced by PPLWHA in an increasingly segregated housing market, as Aidala (2007:S5) noted,

> "Broader structural processes sustaining poverty and inequality may seem beyond the immediate reach of HIV interventions. Fortunately, however, changing housing and neighbourhood environments is both possible and promising."

LIST OF REFERENCES

Abrams, C. (1966). *Housing in the modern world.* London: Faber and Faber.

Acevedo-Garcia, D., Osypuk, T.L., Werbel, E.R., Meara, E.R., Cutler, D.M., Berkman, L.F (2004) Does Housing Mobility Policy Improve Health? *Housing Policy Debate* 15(1), pp. 49-98

Adams, M (2001) *Tenure Security, Livelihoods and Sustainable Land Use in Southern Africa:* Paper presented at the SARPN conference on Land Reform and Poverty Alleviation in Southern Africa. Held in Pretoria, South Africa: June 4-5, 2001. http://oxfam.co.uk/what_we_do/issues/livelihoods/landrights/downloads/adams_tenure.pdf (accessed on 13 November, 2007)

Adams, M., Kalabamu, F., White, R. (2003) Land Tenure Policy and Practice in Botswana-Governance lessons for Southern Africa. *Austrian Journal of Development Studies,* XIX (1), pp. 55-74.

Aidala, A. (2006). *Inequality and HIV: The role of housing. Psychology and AIDS Exchange* Paper presented at the International Workshop on Social Exclusion, Inequality, and Health sponsored by the Watson Institute for International Studies, Brown University, and Providence, RI.

Aidala, A., Sumartojo, E. (2007) Why Housing? *AIDS and Behavior*, 11(Sup 2), pp. 1-6

Aidala, A., Lee, G., Siegler, A. (2007). *Housing Need, Housing assistance and Connection to HIV/AIDS Medical Care.* New York: Columbia University.

Aidala, A. A., Lee, G., Abramson, A., Messeri, P., & Siegler, A. (2007). Housing need, housing assistance and connection to HIV medical care. *AIDS and Behavior*, 11(Sup 2), pp.101-115

Aidala, A., Cross, J., Stall, R., Sumartojo, E., Harre, D. (2005). Housing status and HIV risk behaviors: Implications for prevention and policy. *AIDS and Behavior*, 9(3), pp. 251–265.

Aidala, A., Lee, G. (2000). *Housing Services and Housing Stability Among Persons Living with HIV/AIDS.* New York: Columbia University.

Akintola, O. (2006) Gendered home-based care in South Africa: More trouble for the troubled. *African Journal of AIDS Research* 5(3), pp. 237 - 247

Alder, G (1995) Tackling Poverty in Nairobi's informal settlements: developing an institutional strategy. *Environment and Urbanization* 7 (2), pp. 85 - 108

Alexander, E. M. (2002). *People's Participation and Poverty Alleviation: Making the Difference: The Botswana Experience.* Sociology Department seminar paper, Gaborone: University of Botswana.

Aliber, M., Walker, C., Machera, M., Kamau, P., Omondi, C. and Kanyinga, K. (2004) *The Impacts of HIV/AIDS on Land Rights – Case studies from Kenya.* Rome: FAO. http://www.fao.org/sd/dim_pe3/docs/pe3_040902d1_en.pdf (accessed on 10 March, 2008)

Allen, T. (2000) Housing renewal - doesn't it make you sick? *Housing Studies,* 15(3), pp. 443 - 461.

Allen, T. and Thomas, A (2000) (Eds). *Poverty and Development into the 21ST Century.* Milton Keynes: The Open University.

Anderson, L. M., Charles, J. S., Fullilove, M. T., Scrimshaw, S. C., Fielding, J. E., Normand, J. (2003). Providing affordable family housing and reducing residential segregation by income. *A Systematic Review,* 24(3 Suppl), pp.47–67.

Ankrah, E. M. (1996). AIDS, Socioeconomic Decline and Health: A Double Crisis for the African Woman. In L. Sherr, C. Hankins, L. Bennett (Eds.), *AIDS as a gender issue: psychosocial perspectives.* Oxon: Taylor & Francis

Archer, M., Bhaskar, R., Collier, A., Lawson, T., Norrie, A. (1998) Critical *Realism: Essential Readings.* London: Routledge.

Atkinson, S. J. and Merkle, A. (Eds.), 1993: *Urban Health in Africa.* Report of the WHO/GTZ Workshop on Urban Health in Africa, Harare, 29 November-3 December, London: International Institute for Environment and Development:

Avert (2009) *HIV & AIDS in Botswana.* available at http://www.avert.org/(accessed on 10 September,2009)

Ayling, P., Morris, S., Wakefield, J., Grossinho, A., Jarup, L. & Elliott, P. (2001) Temperature, housing, deprivation and their relationship to excess winter mortality in Great Britain, 1986–1996, *International Journal of Epidemiology,* 30, pp. 1100–1108.

Bautlwatsi C. O (2001). An assessment of implementation of a staff development *innovation and perceived effectiveness of staff development in Botswana Colleges of Education.* Unpublished Ph. D. thesis, University of Wales, Cardiff.

Bardhan, A,. Karapandža R,. and Urošević, B. (2006) Valuing Mortgage Insurance Contracts in Emerging Market Economies. *The Journal of Real Estate Finance and Economics* 32 (1) Pp 9-20. Available at: http://www.springerlink.com/content/v2j15j11240g/?p=80a5a70db8504a60a830a4d91f5a5a97&pi=0 (Accessed on 14 June, 2010)

Barnett, T and Whiteside, A (2006) (2nd Ed). *AIDS in the Twenty-First Century: Disease and Globalization.* New York: Palgrave Macmillan.

Beall, J. (2002). Living in the present, investing in the future: household security among the urban poor in Urban Livelihoods: *A people-centred approach to reducing poverty.* In C. Rakodi, and T. Lloyd-Jones, (Eds.) Earthscan, London.

Benner P. (1994) The tradition and skill of interpretive phenomenology in studying health, illness and caring practices. In P. Benner (ed.), *Interpretive Phenomenology.* Sage, Thousand Oaks, California, pp. 99–127

Berg, B. (2009). *Qualitative Research Methods for the Social Sciences* (7th Ed) London: Allyn and Bacon

Berger, P., Luckmann, T. (1991) (Ed) The *Social Construction of Reality: A treatise in the sociology of knowledge*. London: Penguin Books

Berner, E. (2000) Poverty Alleviation and the Eviction of the Poorest: Towards Urban Land Reform in the Philippines. *International Journal of Urban and Regional Research* 23(4), pp. 554 -566

Besley, T. (1995). Property Rights and Investment Incentives: Theory and Evidence from Ghana. *Journal of Political Economy,* 103(5), pp. 903-937.

Bhaskar, R. (2002) *Reflections on Meta-Reality: A Philosophy for the Present.* New Delhi: Sage.

Bhaskar, R .(1986) *Scientific Realism and Human emancipation.* London:Verso

Bhaskar, R .(1975) *A Realist theory of science (2nd edition).* Leeds: Leeds books Ltd.

Birley, M. H. and Lock, K. (1997) *A Review of the Health Impacts of Peri-Urban Natural Resource Development (Draft Paper).* Liverpool School of Tropical Medicine, Natural Resources International and Natural Resources Systems Programme, United Kingdom Department of International Development: London.

Bishart, L. and Teak, M. (1985) Housing the urban poor in Amman: can upgrading improve health? *Third World Planning Review*, 7(1), pp. 5-22.

Blackman, T. (2006) *Placing Health: Neighbourhood Renewal, Health Improvement and Complexity.* Bristol: Policy Press.

Blackman, T., Anderson, J. and Pye, P. (2003). Change in adult health following medical priority rehousing: a longitudinal study. *Journal of Public Health* 25(1): pp 22-28.

Bloor, M., Wood, F. (2006) *Keywords in Qualitative Methods: A vocabulary of research concepts.* London: Sage Publications.

Boehm, T. P., & Schlottmann, A. M. (1999) Does home ownership by parents have an economic impact on their children? *Journal of Housing Economics*, 8, pp217–232.

Bongaarts, J., Buettner, T., Heilig, G., Pelletier, F (2008) Has the HIV Epidemic Peaked? *Population and Development Review* 34(2), pp. 199-224

Bongaarts, J. (2006) Late Marriage and the HIV Epidemic in Sub Saharan Africa. Working Paper No 216. New York: The Population Council Inc.

Bonoma, T. V. (1985) Case study research in marketing: opportunities, problems and process. *Journal of marketing research*, xxii, pp. 199 -208

Boonstra, E., Lindbæk, M., and Ngome, E. (1985) Adherence to Management Guidelines In Acute Respiratory Infections And Diarrhoea in Children Under 5 Years Old In Primary Health Care In Botswana. *International Journal for Quality in Health Care* 2005; Volume 17 (3), pp. 221–227

Booysen, F. R., Bachmann, M., Matebesi, Z. and Meyer, J. (2004). *The Socio-Economic Impact of HIV/AIDS on Households in South Africa: Pilot Study in Welkom and QwaQwa, Free State Province.* Bloemfontein: Centre for Health Systems Research & Development

Botswana Institute for Development Policy Analysis (2000). *The Macro economic Impacts of the HIV/AIDS Epidemic in Botswana.* Gaborone: BIDPA

Botswana Tourism Board (2006). *A regional map of Botswana.* Gaborone: Department of Tourism. http://www.botswanatourism.co.bw/maps/maps.html (Accessed on June, 2008)

Botswana National Network of People Living with HIV and AIDS (2009) *Advocacy Framework for Problems, Challenges and Issues Facing People Living with HIV and AIDS.* Gaborone: Skillshare International

Braubach, M., Savelsberg, J. (2009) *Social inequalities on housing risk factors and health. A data report based on the WHO LARES database.* Copenhagen: WHO Regional Office for Europe. Available at: http://www.euro.who.int/__data/assets/pdf_file/0013/113260/E92729.pdf (accessed: 10 May 2010)

Bredenoord, J and van Lindert, P. (2010). Pro-poor housing policies: Rethinking the potential of assisted self-help housing. *Habitat International*, 33(2), pp.173-180.

Bruner, J. (1993). The autobiographical process. In R. E. Folkenflick (ed.), *The culture of autobiography: constructions of self-representation.* Stanford, CA: Stanford University Press.

Bryant, T. (2003). The current state of housing in Canada as a social determinant of health. *Policy Options* , March, pp. 52-56

Bryman, A. (2004) (2nd Ed) *Social Research Methods.* Oxford: University Press

Burayo, J. (1991). Long distance truck drivers: Knowledge and attitudes concerning sexually transmitted diseases and sexual behaviour. *East African Medical Journal*, 68, pp. 714-719.

Burgess, R. (1985) The Limits of state Self-Help housing programmes, *Development and change*, 16(2), pp. 271– 312.

Burgess, R. (1982). Self-help housing advocacy: a curious form of radicalism. Acritique of the work of John F.C. Turner. In Ward, P. (Ed.), *Self-help housing. A critique.* London: Mansell.

Caldwell, J. C. (2000). Rethinking the African AIDS Epidemic. *Population and Development Review* 26(1), pp. 117–135.

Campbell, C., & Foulis, C.A. (2004). Creating contexts for effective home based care of people living with HIV/AIDS. *Curatonis, 27,* pp. 5-14.

Campbell, A.C. (1982*). Notes on the Prehistoric Background to 1940 in Botswana Society. Settlement in Botswana.* Gaborone: Heinemann

Carballo, E., Cadarso-Suarez, C., Carrera, I., Fraga, J., de la Fuente, J., Ocampo, A., Ojea, R., and Prieto, A. (2004). Assessing relationships between health-related quality of life and adherence to antiretroviral therapy. *Quality of Life Research,* 13(3), 587–599.

Carney, D. (Ed) (1998) *Sustainable Rural Livelihoods: What Contribution Can We Make?* London: Department for International Development.

Cavrić, B. and Mosha, A. 2001. *Towards better urban development and management in Botswana.* Paper presented at the AESOP Conference at Shanghai, July 11–15, 2001.

Central Intelligence Agency (2006) CIA World Fact Book - Botswana. Available at https://www.cia.gov/library/publications/the-world-factbook/geos/bc.html (accessed on 10 June 2010)

Centre for Addiction and Mental Health (CAHM) (2007). *Making Housing a Priority for People with HIV/AIDS in Ontario.* Available at www.nationalaidshousing.org/.../HousingSolutionsFINALREPORTJuly2007.pdf (accessed: June 2010)

Chaggu, E. J (2004) *Sustainable Environmental Protection using modified pit-latrines.* Unpublished Ph. D. thesis, Wageningen University. The Netherlands.

Channock, M (1991) Paradigms, Policies and Property: A review of the customary Law of Land Tenure. In K. Mann, and R. Roberts, (Eds). *Law in colonial Afric*a. Portsmouth: Heinemann.

Clapham, D (2009) Introduction to the Special Issue - A Theory of Housing: Problems and Potential. *Housing, Theory and Society* 26 (1), pp. 1-9

Cisneros (2007) Policy Perspectives on Housing and HIV/AIDS. *AIDS and Behavior,* 11(Sup 2), pp.S6-S7.

Coffey, A., Atkinson, P. (1996) *Making Sense Of Qualitative Data: Complementary Research Strategies.* London: Sage Publications

Cohen, D (2002) *HIV Epidemic and other crisis response in Sub Saharan Africa. In Focus Programme on Crisis Response and Construction* Working Paper No 6. Geneva: International Labour Organisation. Available at: http://www.ilo.mirror.cornell.edu/public/english/employment/recon/crisis/download/wp6.pdf (accessed 12 November, 2007)

Collins, J., Rau, B (2000) *AIDS in the context of development.* UNRISD Programme on Social Policy and Development, Paper Number 4.

Conover, C. J., and Whetten-Goldstein, K. (2002). The impact of ancillary services on primary care use and outcomes for HIV/ AIDS patients with public insurance coverage. *AIDS Care,* 14(Suppl 1), pp.S59–71.

Cooper, D., Pick, W. M., Myers, J. E., Hoffman, M. N., Sayed, A. R. and Klopper, J.M. L., (1991). Urbanisation and women's health in Khayelitsha: Part I. Demographic and socio-economic profile, *South African Medical Journal*, 79, pp. 423-7.

Corbin J,. Strauss A. (2008) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* London: Sage Publications

Cotula, L. (Ed) (2007) *Changes in "customary" land tenure systems in Africa.* Hertfordshire: Russell Press.

Cotula, L., Toulmin, C., Hesse, C. (2004) *Land Tenure and Administration in Africa: Lessons of Experience and Emerging Issues.* London: International Institute for Environment and Development.

Crampin, A. C., Mwaungulu, J. N., Mwaungulu, F.D., Mwafulirwa, D.T., Munthali, K., Floyd, S., Fine, P.E., Glynn, J. R. (2010) Recurrent TB: Relapse or reinfection The effect of HIV in general population cohort in Malawi. *AIDS* 24 (3), pp. 417 -426

Creswell, J. W (2009) *Research Design: Qualitative, Quantitative and Mixed methods approaches.*(3rd Edition). London: Sage Publications

Creswell, J. W (1994) *Research Design: Qualitative and Quantitative approaches.* London: Sage Publications

Cockcroft, A., Andersson, N., Milne, D., Mokoena, T and Masisi, M (2007) Community views about routine HIV testing and antiretroviral treatment in Botswana: signs of progress from a cross sectional study. *BMC International Health and Human Rights,* 7:5 pp 1-11. Available at http://www.biomedcentral.com/1472-698X/7/5 (accessed 27 September 2009)

Crossan, F (2003). Research philosophy: Towards an understanding. Nurse Researcher, 11(1), pp. 46-55

Cunningham, W. E., Andersen, R. M., Katz, M. H., Stein, M. D., Turner, B. J., Crystal, S (1999). The impact of competing subsistence needs and barriers on access to medical care for persons with human immunodeficiency virus receiving care in the United States. *Medical Care*, 37(12), pp. 1270–1281.

Daly, G (1996) *Homelessness and the Street: Observations from Britain, Canada and the United States. In Fyfe, N. R (Ed.), Images of the street: planning, identity and control in public space.* London: Routledge

Dasinger, L. K., and Speiglman, R. (2007). Homelessness prevention: The effect of a shallow rent subsidy program on housing outcomes among persons with HIV and AIDS. *AIDS and Behavior*, 11(6), pp.S128-S139.

Datta, K. (1999). A gendered perspective on formal and informal housing finance in Botswana. In Datta, K and Jones, G. A. (Eds.) *Housing and Finance in developing countries*. London: Routledge.

Datta, K. (1996) The Organisation and perfomance of a low income rental market: The case of Gaborone, Botswana. *Cities,* 13 (4), pp.237-245.

Datta, K. (1995) Strategies for urban survival? Women landlords in Gaborone, Botswana, *Habitat International,* 19 (1), pp. 1-12.

Datta, K., Jones, G. A. (2001) Housing and finance in developing countries: invisible issues on research and policy agendas. *Habitat International* 25 (3), pp. 333-357.

DCDM Botswana (2006) *Consultancy services for the Botswana public officers' housing fund feasibility study: Feasibility Report.* Gaborone: DCDM Botswana (Pty) Limited

De Cock, KM, Mbori-Ngacha, D and Marum, E. (2002). Shadow on the continent: Public health and HIV/AIDS in Africa in the 21st century. *The Lancet,* 360, pp. 67-72.

De Cock, K.M., Fowler, G. M., Mercier, E., de Vincenzi, I., Saba, J., Hoff, E., Alnwick, D. J., Rogers, Shaffer, N (2000) Prevention of Mother-to-Child HIV Transmission in Resource-Poor Countries: Translating Research Into Policy and Practice *JAMA* 283 (9), pp.1175-82

Decosas, J (2002) *The Social Ecology of AIDS in Africa.* Paper prepared for the UNRISD project HIV/AIDS and Development March 2002. Harare: Zimbabwe

Decosas, J. and Adrien, A (1997). Migration and HIV. *AIDS*, 11, (Suppl. A), pp. S77 - S84

Denzin, N. K. (1989), *The research act: A theoretical introduction to sociological methods.*London: Prenticehall International

Development Works, (2002). *Economic impact of HIV/AIDS on the Construction Sector and in turn on the Housing Policy. Final Report.* Research paper sponsored by USAID and administered by the Joint Centre for political and Economic Studies Inc. under a subcontract agreement from Nathan Associates Inc. Johannesburg, June.

Dey J. (1993) Qualitative *Data Analysis: A user friendly guide for Social Scientist.* London: Routledge.

Diamond, D. and Lee, M. (1992) Housing finance in developed countries: an international comparison of efficiency. *Journal of Housing Research* 3 (1), pp. 1 -260

Drimie, S (2002) *The Impact of HIV/AIDS on Rural Households and Land Issues in Southern and Eastern Africa.* A Background Paper prepared for the Food and Agricultural Organisation, Sub-Regional office for Southern and Eastern Africa.

Dunn, J. R. (2000). Housing and health inequalities: *Review and prospects for research. Housing Studies,* 15 (3), pp.341–366

Dunn, J. R. (2002). *A population health approach to housing: A framework for research. Department of Community Health Services,* University of Calgary. Available at http://www.hpclearinghouse.ca/hcn/download/A_Population_Health_Approach_to_ Housing_FINAL.pdf

Durand-Lasserve, D. and Clerc, V (1996) r*egularization and integration of irregular settlements - Lessons from experience*: Working Paper No. 6 UND/UNCHS/WORLD BANK-UMP: Kenya

Econsult Botswana (2006) *The Economic Impact of HIV/AIDS in Botswana:* A final Report prepared for National AIDS Co-ordinating Agency (NACA) and United Nations Development Programme (UNDP).

Elifson, K. W., Sterk, C. E., & Theall, K. P. (2007). Safe living: The impact of unstable housing conditions on HIV risk reductionamong female drug users. *AIDS and Behavior,* 11(Sup 2), pp. 44-55

Engels, F. (1872) *The Housing Question,* 1935 (edition) New York.

Esposito, R (2001) From Meaning to Meaning: The Influence of Translation Techniques on Non-English Focus Group Research. *Qualitative Health Research* 11 (4) pp.568-574. Available at: http://qhr.sagepub.com/cgi/reprint/11/4/568. Accessed 05 November, 2009.

Evans, G., Wells, N., and Moch, A. (2003). Housing and mental health: A review of the evidence and a methodological and conceptual critique. *Journal of Social Issues, 59*(3), pp. 475-500

Fairclough, N., Jessop, B. and Sayer, A. (2003). Critical realism and semiosis. In J. M. Roberts and J. Joseph (Eds.), *Realism Discourse and Deconstruction* (pp 32-34) London: Routledge

FinMark Trust (2007) *Access to housing finance in Africa: exploring the issues: Overview of the housing finance sector in Botswana.* FinScope™ Botswana 2007

Fitzpatrick, S (2005) Explaining Homelessness: A critical Realist Perspective. *Housing Theory and Society* 22 (1), pp. 1-17

Flick, U (2006) *An Introduction to Qualitative Research.* (3rd Ed) London: Sage Publications

Flick, U (2009) *An Introduction to Qualitative Research.* (4th Ed) London: Sage Publications

Foster, G. and Williamson, J. (2000) A review of current literature of the impact of HIV/AIDS on children in sub-Saharan Africa. *AIDS*, 14 (suppl. 3), pp. S275-S284

Foster, G., Makufa, C., Drew, R and Kralovec (1997) Factors Leading to the Establishment of Child-Headed Households: The Case of Zimbabwe. *Health Transition Review,* 7 (2 Sup), pp. 155-168

Fuller-Thomson, E., Hulchanski, J.D. and Hwang, S. (2000) The housing/health relationship: What do we know? *Review of Environmental Health.* 15 (1-2), pp. 109-133.

GeoSolutions. (2007). *The review of the self help housing agency (SHHA) programme.* Gaborone: Ministry of Lands and Housing

Gilbert, A. (1993). *In search of a home: Rental and shared housing in Latin America.* London: UCL Press.

Gilbert, A. (1983) The tenants of self-help housing: Choice and constraint in the housing markets of less developed countries. *Development and Change,* 14: pp 449-477.

Gingles, E. J., McErlain, M. S., McPeake, J. W. R. and Reavie, L. (1995) *Health and Housing Study,* Department of Public Health Medicine, Eastern Health and Social Services Board and Research Unit, Belfast: Northern Ireland Housing Executive.

Girardet, H. (1996). *The Gaia Atlas of Cities; new directions for sustainable living,* London: Gaia Books Limited.

Global Coalition on Women and AIDS (2006) *Keeping the Promise: An Agenda for Action on Women and AIDS.* Nations Publication: New York. Available from http://womenandaids.unaids.org (accessed 13 September 2007).

Goebel, A. (2007) Sustainable urban development? Low-cost housing challenges in South Africa. *Habitat International* 31 (3-4), pp. 291-302.

Gomm, R., Hammersley M., Forset, P. (2000) (Ed) *Case Study Method: Key Issues, Key Texts.* London: Sage Publications

Gordon, D., Levitas, R, Pantazis, C., Patsios, D., Payne, S., Townsend, P., Adelman, L., Ashworth, K., Middleton, S., Bradshwaw, J., Williams, J. (2000) *Poverty and Social Exclusion in Britain.* York: Joseph Rowntree Foundation

Goromosov, M. S. (1968) The *Physiological Basis of Health Standards for Dwellings.* Public Health Papers No. 33. Geneva: World Health Organisation

Government of Botswana (2010) *Budget Speech 2010.* Gaborone: Government Printers.

Government of Botswana (2009) *The Department of Housing projects and programmes.* Available at http://www.mlh.gov.bw/index.php?option=com_departments&id=27 (accessed on 20 April 2010)

Government of Botswana (2008) *Policy Guidance to Male Involvement in SRH, HIV/AIDS and Gender Based Violence. Prevention and Management: An addendum to sexual and reproductive health (SRH) Policy Guidelines and service standards* (2008). UNFPA. Gaborone.

Government of Botswana (2008) Unpublished *Report on the disbursement of SHHA loans since inception up to March 2008.* Briefing report to the Permanent Secretary and Minister of Lands and Housing. Gaborone.

Government of Botswana (2007) *State of the Nation Address: Renewal through mutual responsibility.* Gaborone: Government Printers.

Government of Botswana (2003). *2001 Population and Housing Census Dissemination Seminar.* Gaborone: Government Printers.

Government of Botswana (2002a) *National Development Plan 9.* Gaborone: Government Printers.

Government of Botswana (2002b). *Population and Housing Census: Population of Towns, Villages and Associated Localities, 2001 Census.* Gaborone: Government Printers.

Government of Botswana (2002c). *Revised National Policy on Destitute Persons: Ministry of Local Government Social Welfare Division.* Gaborone: Government Printers.

Government of Botswana ed. (2001).*Botswana National Atlas.* Gaborone: Department of Surveying and Mapping

Government of Botswana (2000) *Government Paper No. 2 of 2000 on National Policy on Housing in Botswana.*Gaborone: Government Printers.

Government of Botswana (1998). *1995/96 Labour Force Survey*: Gaborone. Government Printers.

Government of Botswana (1997) *National Development Plan 8.* Gaborone: Government Printers.

Government of Botswana (1992) *Review of the Self-help Agency. Ministry of Local Government, Lands and Housing.* Gaborone: Government Printers.

Government of Botswana (1990) *Allocation of State Land: New Policy. Ministry of Local Government, Lands and Housing.* Gaborone: Government Printers.

Government of Botswana (1983) *An Evaluation of Self-help Agencies Ministry of Local Government and Lands*, Gaborone: Government Printers

Government of Botswana (1982) *National Policy on Housing.* Gaborone: Government Printers.

Grant, R.W., Sugarman, J. (2004) Ethics in Human Subjects Research: Do Incentives Matter? *Journal of Medical and Philosophy*, 26 (6), pp. 717 - 738

Greener, R., Jefferis, K., Siphambe, H. (2000). The Impact of HIV/AIDS on Poverty and Inequality in Botswana, *South African Journal of Economics*, 68, (5), pp. 888 - 915.

Grimes, O.F. Jr. (1976). *Housing for Low-Income Urban Families: Economics and Policy in the Developing World.* London: John's Hopkins University Press

Gwebu, T. D. (2003) Environmental problems among low income urban residents: an empirical analysis of Old Naledi-Gaborone, Botswana. *Habitat International* Vol. 27(3), pp. 407-427.

Hamel, J., Dufour, S., & Fortin, D. (1993). *Case study methods.* Newbury Park, CA: Sage Publications.

Hammet, I (1975) *Chieftainship and legitimacy: An Anthropological study of Executive Law in Lesotho.* London: Routledge and Kegan Paul.

Harpham, T., Lusty, T. and Vaughan, P., (1988). *In the Shadow of the City: Community Health and the Urban Poor.* Oxford University Press: Oxford.

Harvey, C. and Lewis, S. (1990) *Policy Choice and Development Performance in Botswana.* London: MacMillan.

Heald, S (2006) Abstain or Die: The Development of HIV/AIDS Policy in Botswana. *Journal of Biosocial Science* 38(1), pp. 29 - 41.

Homan, R (1991) *The Ethics of Social Research.* London: Longman

Home, R., Lim, H (Eds) (2004) *Demystifying the Mystery of Capital: Land Tenure and Poverty in Africa and the Caribbean.* London: Cavendish Publishing Limited.

Hope, K. R. (1996) Growth, Unemployment and Poverty in Botswana. *Contemporary African Studies*, 14 (1), pp. 53-67.

Hopton J.L. and Hunt, S.M. (1996) Housing conditions and mental health in a disadvantaged area in Scotland. *Journal of Epidemiology and Community Health* 50, pp. 56-61

Huberman, A.M., Miles, M.B (2002) *The Qualitative Researcher's companion.* London: Routledge.

Huchzermeyer, M (2001) Housing for the Poor? Negotiated housing policy in South Africa. *Habitat International* 25(3), pp. 303-331.

Human Rights Watch (2003a) *Just Die Quietly: Domestic Violence and Women: Vulnerability to HIV in Uganda.* Available at www.hrw.org/reports/2003/Uganda 0803 (accessed 06 November 2007).

Human Rights Watch (2003b) Double Standards: *Women's Property Rights Violations in Kenya.* Available at www.hrw.org/reports/2003/kenya0303 (accessed 06 November 2007).

Human Rights Watch (2002) *Suffering in silence: The Links between Human Rights Abuses and HIV Transmission to girls in Zambia.* London: Human Rights Watch

Human Rights Watch (2001) *In the shadow of death: HIV/AIDS and children's rights in Kenya*, Human Rights Watch 13(4–A).

Human Sciences Research Council (HSRC) (2002) *The impact of HIV/AIDS on land: Case studies from Kenya, Lesotho and South Africa.* A synthesis report prepared for the Southern African Regional Office of the Food and Agricultural Organization of theUnited Nations.

Hussey, J. and Hussey, R. (1997), *Business research,* Macmillan, Press Ltd.

Hyndman, S. J. (1990) Housing dampness and health amongst British Bengalis in East London. *Social Science and Medicine*. 30 (1), pp. 131-141.

Ikejiofor, U. (1997). The private sector and urban housing production process in Nigeria: A study of small-scale landlords in Abuja. *Habitat International*, *21*(4), pp. 409 - 425.

Ikgopoleng, H., Cavrić, M. (2007). An evaluation of the self-help housing scheme in Botswana, case of Gaborone city. *Spatium* 15 (16), pp. 28-36.

International Human Rights Internship Program (2000) *Circle of rights: Economic, social & cultural rights activism, a training resource. A right to adequate housing.* Accessed at http://www1.umn.edu/humanrts/edumat/IHRIP/circle/modules/module13.htm

Janesick, V. J. (1994) The dance of qualitative research design: metaphor, methodolatry and meanings in N. K. Denzin and Y. S. Lincoln (Eds.), *Handbook of qualitative research*, Sage Publications, pp. 109 -119

Jeffries, K (2007) *Enhancing Access to Banking and Financial Services in Botswana. Gaborone: Lentswe la Lesedi Publishers*

Johnson, M. O., Catz, S. L., Remien, R. H., Rotheram-Borus, M. J., Morin, S. F., Cheryl Gore-Felton, E. C., Goldsten, R. B., Lightfoot, H. F., and Chesney, M. A. (2003) Theory-Guided, Empirically Supported Avenues for Intervention on HIV Medication Non-adherence: Findings from the Healthy Living Project. *AIDS Patient Care and STDs*. 17(12): pp 645-656.

Kalabamu, F.T. (2006) The limitations of state regulation of land delivery processes in Gaborone, Botswana. *IDPR*, 28 (2), pp. 209 -234

Kalabamu, F.T. (2005) *Changing roles of women in housing processes and construction: The case of Lobatse Township, Botswana.* Unpublished Ph. D. thesis, University of Kwa-Zulu Natal, South Africa.

Kalabamu, F.T. and Morolong, S, (2004) *Informal Land Delivery Processes and Access to Land for the Poor in Greater Gaborone.* Birmingham: The University of Birmingham.

Kalabamu, F.T. (2003) Changing gender contracts in self-help housing construction in Botswana: The case of Lobatse. *Habitat International* 29 (2), pp. 245-268.

Kalabamu, F. T. (2000). Land tenure and management reforms in East and Southern Africa. *Land Use Policy* 17 (4), pp. 305-319.

Kalichman, S.C. (2007). Recent multiple sexual partners and HIV transmission risks among people living with HIV and AIDS in Botswana., *Aug*: 83 (5), pp.371-375

Kalipeni, E., Craddock, S., Oppong, J. R., Ghosh, J. (2004) *HIV & Aids in Africa: Beyond Epidemiology.* Oxford: Blackwell Publishing.

Kamusiime, H., Obaikol, E., and Rugadya, M. (2004) *Integrating HIV/AIDS in the Land Reform Process.* Kampala: Associates for Development

Kearns, R.A. (1995) Worried sick about housing: extending the debate on housing and health, *Community Mental Health in New Zealand*, 9 (1), pp. 5–11.

Kearns, R.A. & Smith, C.J. (1993) Housing stressors and mental health among marginalised urban populations, *Area*, 25(3), pp. 267–278.

Keiner, M. and Cavrić, B. I. (2006) Managing Development of a Rapidly Growing African City: a Case of Gaborone, Botswana. *Geoadria* 11(1), pp. 93-121

Kerr, D., Kwele, N (2000) Capital Accumulation and the Political Reproduction of the urban housing problem in Botswana. *Urban Studies* 37 (2), pp. 1313-1345

Kerton. G.A.J.(2007) *Vocational education and training in Botswana.* Unpublished Ph. D. thesis, Cardiff University, Wales.

Kiai, W., Mwangi, W., Bosire. (2002) *The Impact of HIV/AIDS on the Land Issue in Kenya.* Nairobi: Forest Action Network.

King, P (2009) Using Theory or Making Theory: Can there be theories of Housing? *Housing, Theory and Society* 26 (1), pp. 41-52

King, P. (2003). *A social philosophy of housing.* Hampshire: Ashgate Publishing Company

Kironde, J. (2005) *Current changes in customary land systems in sub-Saharan African cities: the case of Dar es Salaam city.* Tanzania. Unpublished Report

Kumar, S. (2001) *Social relations, rental housing markets and the poor in urban India.* London: Department of Social Policy, London School of Economics.

Kumar, S. (1996). Subsistence and petty capitalist landlords: A theoretical framework for the analysis of Landlordism in Third World urban low income settlements. *International Journal of Urban and Regional Research*, 20 (2), pp. 317-329

Krieger, J., & Higgins, D. L. (2002). Housing & health: Time again for public health action. *American Journal of Public Health*, 92, pp. 758–768.

Larsson, A. (1989). *Women Householders and Housing Strategies: The Case of Gaborone, Botswana.* Gavle: National Swedish Institute for Building Research.

Lawson, *J. (2006) Critical Realism and Housing Research.* London: Routledge,

Leaver, C. A., Bargh, G., Dunn, J. R., & Hwang, S. W. (2007). The effects of housing status on health-related outcomes in people living with HIV: A systematic review of the literature. *AIDS and Behaviour* 11(Sup 6), pp.85-100

Leduka, R. C. (2000). *The role of the state, law and urban social actors in illegal urban development in Maseru Lesotho.* Unpublished Ph. D. thesis, University of Wales, Cardiff.

Letamo, G (2003) Prevalence of, and Factors associated with HIV/AIDS - related stigma and discriminatory attitudes in Botswana. *Journal of Health, Population and Nutrition* 21 (4), pp. 347-357

Letamo, G. and Bainame, K. (1997). The socio-economic and cultural context of the spread of HIV/AIDS in Botswana. *Health Transition Review*, 7 (Suppl 3), pp. 97-101.

Lengwe- Katumbela, M., Lucas, T.,Osei-Hwedi, K. (1998) The Practice of Social Policy in Botswana. *Journal of Social Development in Africa* 13 (2), pp. 55-74

Lewis, P. (2001) Realism, Causality and the problem of social structure. *Journal for the Theory of Social Behaviour* 30 (3), pp. 249 - 268

Lieb, S., Robert, B., Hopkins, R. Thompson, D. Crockett, L., Liberti, T., Jani, A., Nadler, J., Virkud, V., West, K., and. McLaughlin, G. (2002) Predicting Death from HIV/AIDS: A Case-Control Study from Florida Public HIV/AIDS Clinics. *Journal of Acquired Immune Deficiency Syndromes* 30 (3), pp.351-358.

Lim, H (2004) Inheritance, HIV/AIDS and Children's Rights to Land in Africa. In Home, R. and Lim, H. *Demystifying the Mystery of Capital: Land Tenure and Poverty in Africa and the Caribbean.* London: The Glass house press

Lindsey, E., Hirschfeld, M and Tlou, S (2003) Home based care in Botswana: Experience of older women and young girls. *Health Care Women International* 24 (6), pp. 486-501

Loewenson, R and Whiteside, A (2001) *HIV/AIDS Implications for poverty reduction*; A paper prepared for the UNDP for the United Nations General Assembly Special Session on HIV/AIDS, 25-27 June 2001.

Lowry S.(1990) Health and homelessness. *BMJ* .300, pp. 32-34

MacFarlan, M. and Sgherri, S (2001) *The Macroeconomic Impact of HIV/AIDS in Botswana*. International Monetary Fund Working Paper No: WP:01/80.

Machina, H (2002) *Women's Land Rights in Zambia: Policy Provisions, Legal Framework and Constraints.* Paper presented at the Regional Conference on Women's Land Rights, held in Harare, Zimbabwe, from 26 - 30 May 2002. http://oxfam.co.uk/what_we_do/issues/livelihoods/landrights/downloads/womenzam.rtf. (Accessed on 13 November, 2007)

MacLellan, M (2005) *Child-headed Households: Dilemmas of definition and livelihood rights.* Unpublished paper presented at the ' 4th World Congress on Family Law and Children's rights" Cape Town March 2005. http://www.childjustice.org/docs/maclellan2005.pdf (accessed 29 September 2009)

Madhavan, S. and Schatz. E. (2007). Household Structural and Compositional Change in Rural South Africa: 1993-2003. *Scandinavian Journal of Public Health,* 35 (supplement 69), pp. 85-93.

Mak, K (2005) *Engendering Property Rights: Women's Insecure Land Tenure and Its Implications for Development Policy In Kenya and Uganda.* http://www.princeton.edu/~jpia/pdf2005/chapter%2007%20Mak.pdf (accessed 12 November 2007)

Malpass, P. and Dumba, D. (2000). *The development of low income urban housing markets: A case study of the Republic of Botswana.* Paper presented to the European Network for Housing Research. Housing in the 21st century: Fragmentation and Reorientation 26 - 30 June 2000, Gävle, Sweden

Mangin,W. (1967). Latin American squatter settlements: a problem and a solutiuon *Latin American Research Review*, 2, pp. 67-98.

Marcus, T. (2001). Is there an HIV/AIDS demonstration effect? Society in Transition, The *Journal of the South African Sociological Association,* (32)1.

Markus, T. A. (1993) Cold, condensation and housing poverty. In R. Burridge & D. Ormandy (Eds) *Unhealthy Housing: Research, Remedies, and Reform.* London: E & FN Spon.

Marsh, A (1999) Housing and health: the nature of the connection. *Radical Statistics Journal,* 72 (7) available at http://www.radstats.org.uk/no072/article7.htm (accessed on 20 0ctober, 2009)

Martin, C.J., Platt, S.D. and Hunt, S.M. (1987) Housing conditions and ill health. *BMJ* 294 (6580), pp. 1125–1127.

Martin, A. E. (1977). *Health Aspects of Human Settlements* (Ed.), Public Health Papers 66, World Health Organisation: Geneva.

Masanjala, W. (2007) The Poverty -HIV/AIDS nexus in Africa: A livelihood approach. *Social Science and Medicine*, 64, pp. 1032 -1041

Mason, J. (2002) *Qualitative Researching* (2nd Edition) London: Sage Publications.

Mathéy, K. (Ed) (1992) *Beyond self help housing.* London: Mansell.

Mathuba, B. M. (2003). *Botswana Land Policy.*International Workshop on Land Policies in Southern Africa. Berlin, Germany.

Matte, T. D. and Jacobs, D. E. (2000) Housing and health: Current issues and implications for research and programs. *Journal of Urban Health.* 77, pp. 7–25.

Maundeni, Z. (2004). *Mapping Local Democracy in Gaborone City.* Gaborone: Botswana Association of Local Authorities.

Maundeni, Z. (2000). *Children's experiences of divorce in Botswana.* Unpublished Ph. D thesis, Glasgow University, Scotland.

May, A. (2003). *Social and Economic Impacts of HIV/AIDS in Sub-Saharan Africa, with Specific Reference to Aging.* A Working Paper. Boulder CO: Population Aging Center.

May, T. (2001) *Social Research: Issues, Methods and Process.* Buckingham: Open University Press.

Mbaya, S (2002) *HIV/AIDS and its Impact on Land Issues in Malawi.* A paper presented at a FAO/SARPN Workshop on HIV/AIDS and Land. 24th-25th June 2002, Pretoria, South Africa. http://oxfam.co.uk/what_we_do/issues/livelihoods/landrights/downloads/malhiv.pdf (accessed on 14 November, 2007)

McKechnie, A. (2007) *Beyond Barriers: A critical Realist perspective on disability and the meaning of the dwelling.* Unpublished Ph. D thesis, Cardiff University, Wales.

Midheme (2007) *State vs. community led land tenure regularisation in Tanzania: The case of Dar es Salaam city,* Unpublished Masters dissertation, International Institute for Geo- Information Science and Earth Information, Enschede: The Netherlands *available at:* www.itc.nl/library/papers_2007/msc/upla/midheme.pdf (accessed on 10 May 2010)

Ministry of Local Government, Lands and Housing (1990) *An Analysis of Providing Serviced Land and Housing in Botswana's Seven Centres.* Unpublished report.

Mitlin, D. (2007). Finance for low-income housing and community development. *Environment & Community Development* 19 (2), pp. 331–336.

Mitlin, D. (1997) Building with credit: housing finance: housing finance for low-income households. *Third World Planning Review*, 19(1), pp. 21–50.

Mmegi wa Dikgang (21 May 2009) *Land Repossession.* Newspaper article: Available at: http://www.mmegi.bw/index.php?sid=2&dir=2010/April/Wednesday21 (accesed 2010)

Mmegi wa Dikgang (09 May 2009) *New SHHA scheme to deliver 1000 houses.* Newspaper article: Available at: http://www.mmegi.bw/index.php?sid=4&aid=12&dir=2009/March/Monday9 (accesed 2009)

Mmegi wa Dikgang (16 May 2006) *BHC still stuck to its mandate-CEO.* Newspaper article: Available at: http://www.mmegi.bw/2006/May/Tuesday16/4446677671295.html (accesed 2007)

Monkge, C.B. (2001) *Education, Skills formation and economic development: the case of Botswana*, unpublished PhD thesis, Cardiff University, Wales.

Moore, A. R. and Oppong, J (2007) Sexual Risk Behavior among People Living with HIV/AIDS in Togo. *Social Science & Medicine* 65, pp. 20-31

Mooya, M. M., Cloete, C. E (2007) Informal Urban Property Markets and Poverty Alleviation: A Conceptual Framework. Urban Studies 44 (1), pp. 147 -165

Morton, J. S (1999) Housing Low income families: Problems, Programs, prospects. *Journal of Housing and Community Development* 56 (5), pp.30-37

Moser, C., and Satterthwaite, D. (2010) Towards pro-poor adaptation to climate change in the urban centers of low- and middle-income countries. In R. Mearns and A. Norton (eds) *Social Dimensions of Climate Change*, Washington DC, World Bank

Moser, C. (1998). The asset vulnerability framework: reassessing urban poverty reduction strategies. *World Development* 26(1): pp1-19.

Mosha, A. C. (2004) *Challenges of Municipal Finance in Africa- Gaborone City, Botswana.* Paper presented at a conference on "The challenges of city financing: Habitat's Professionals Forum and Land and Urban Poverty Organised by the Habitat Professionals Forum and the UN-Habitat 2nd World Urban Forum. Barcelona, Spain 13-17 September.

Mosha, A. C. (1996). An evaluation of Botswana's strategies to regularize informal settlements. *Review of Urban and Regional Development Studies* 8, pp. 46–65.

Mosha, A. C. (1995). An evaluation of physical planning strategies and programmes for housing the urban poor in Botswana. In Mosha, A. C.(Ed)A reappraisal of the urban planning process. Nairobi: UNCHS

Msellati, P., Juillet-Amari, A., Prudhomme, J., Akribi, H.A., Coulibaly-Traore ,D. and Souville, M. (2003) Socio-economic and health characteristics of HIV-infected patients seeking care in relation to access to the Drug Access Initiative and to antiretroviral treatment in Cote d'Ivoire. *AIDS* 17 (Suppl. 3), pp. S63–S68.

Musole, M. (2007) *Land Policy and the urban land market in Zambia: Property Rights, Transaction costs and institutional change.* Unpublished Ph. D thesis, University of Glasgow, Scotland.

Musyoki, A. (1998) Perceptions on Gender and Access to Housing in Botswana. In Larsson et al.(Editors) *Changing Gender Relations in Southern Africa: Issues of Urban Life*. ISAS, National University of Lesotho, Roma, Lesotho pp.266-285

Mwansa, L. K., Taolo, L., Osei-Hwedi, K. (1998) The Practice of Social Policy in Botswana. *Journal of Social Development in Africa* 13 (2), pp. 55-74

Naidoo, J., and Wills, J. (Ed) (2001). *Health Studies: An Introduction.* Basingstoke: Palgrave.

National AIDS Coordinating Agency (2006) *The Economic Impact of HIV/AIDS in Botswana.* Gaborone: Econsult.

National AIDS Housing Coalition (2008), I*nternational Declaration on Poverty, Homelessness and HIV/AIDS.* Available at: http://nationalaidshousing.org/2008/07/endorseconference/

National AIDS Housing Coalition. (2007*). Transforming Fact into Strategy –Developing a Public Health Response to the Housing Needs of Persons Living with and At Risk of HIV/AIDS*: Policy Paper from the Second National Housing and HIV/AIDS Research Summit. Washington, DC.

National AIDS Housing Coalition. (2005). *Housing is the Foundation of HIV Prevention and Treatmen*t: Results of the National Housing and HIV/AIDS Research Summit. Washington, DC.

Ndaba-Mbata, R. and Seloilwe, E(2000) Home-based care of the terminally ill in Botswana: knowledge and perceptions. *International Nursing Review* 47 (4), pp. 218–223.

Ndadi, U. (2008) HIV/AIDS and employment law in Botswana. *The Botswana Review of Ethics, Law and HIV/AIDS.* 1 (2), pp.43 - 54

Nkosana J.M (2006) *Intergenerational sexual relationships in urban Botswana.* Unpublished PhD thesis: University of Melbourne, Australia. Available at www.eprints.infodiv.unimelb.au/archive: (accessed 20 August 2010)

Nkurunziza, E and Rakodi, C. (2005). *Urban Families under Pressure: Conceptual and Methodological Issues in the study of poverty, HIV/AIDS and livelihood strategies.* Birmingham: University of Birmingham International Development Department.

Nkurunziza, E. (2008) *Understanding informal urban land access processes from a legal pluralist perspective:* The case of Kampala, Uganda. Habitat International 32 (1), pp. 109-120

Nkwae, B. and Dumba, D. (2010). From certificate of rights to long-term leaseholds in botswana. *Habitat International* 34 (4), pp. 367 -373

Nussbaum, L. (2010) *More than just a roof over my head: Housing for people living with HIV/AIDS around the world* (Ed.). Washington, DC: National AIDS Housing Coalition

Ogotu, G. (2002) *Home Based care services by community based organisations (CBOs) on HIV/AIDS program as best solution for decongesting the hospitals.* (Presentation at the XIV International AIDS conference, 2002 Barcelona, July 7 -12)

Oldman, C. & Beresford, B. (2000) Home sick home: using the housing experiences of disabled children to suggest a new theoretical framework, *Housing Studies*, 15(3), pp. 429 - 442.

Omar, A. A (2003) *.An evaluation of low income housing project in developing countries case study: Tripoli-Libya.* Unpublished Ph. D thesis, University of Salford, England.

Omuojeni, E. O. (2006) *Housing the poor – A vehicle for poverty alleviation in Nigeria.* Available at:http://www.scribd.com/doc/24593366/Housing-A-Vehicle-for-Poverty-Alleviation-Research (accessed 12th July 2010)

Oppong, J.R and Kalipeni (2004) Perceptions and Misperceptions of AIDS in Africa. In Kalipeni, E., Craddock, S., Oppong, J.R., Ghosh, J (Ed.), *HIV/AIDS in Africa: Beyond Epidemiology.* Oxford: Blackwell Publishing

Osei-Hwedi, K. (2004) Poverty Eradication in Botswana: Towards the realisation of Vision 2016. *Pula: Botswana Journal of African Studies* 18 (1), pp. 7-18

Osei-Hwedie, K. (2001). *Social Policy and Poverty Alleviation in Botswana.* Paper presented at the Southern African Universities Social Science Conference, Windhoek, 2-5 December 2001.

Page, A. (2002) Poor Housing and Mental Health in the United Kingdom: Changing the Focus for Intervention. JEHR 1 (1) available at http://www.cieh.org/JEHR/housing_mental_health.html (accessed on 21 August 2010)

Parker, M . and Wilson, G (2000) Disease and Poverty. In Allen, T. and Thomas, A (Ed.). *Poverty and Development into the 21ST Century.* Milton Keynes: The Open University. pp 75 -98

Parkinson, J. (2008) Improving servicing of on-site sanitation – a neglected issue for the UN Year of Sanitation. *Water21*, December , pp. 40 - 42

Parkinson. S, Nelson. S., Horga, S (1999) From Housing to Homes: A Review of the Literature on Housing Approaches for Psychiatric Consumer/Survivors. *Canadian Journal of Community Mental Health*, 18 (1), pp. 145 - 164

Peng, K. K. (1989) *Housing for the people : why Malaysia has so far failed to meet housing needs of the poor* Penang: Consumers Association of Penang and Southeast Asian Forum on Development Alternatives.

Pevalin, D. J., Taylor, M. P., Todd, J (2008). The dynamics of unhealthy housing in the UK: A panel data analysis. *Housing studies,* 23 (5), pp. 679 -695.

Phiri, S. and Webb, D. (2002). The Impact of HIV/AIDS on Orphans and Program and Policy Responses. Cornia, G.A (Ed.), *AIDS*, Public Policy and Child Well-Being, UNICEF

Physicians for Human Rights (2007) *Epidemic of Inequality, Women's Rights and HIV AIDS in Botswana and Swaziland: An Evidence-Based Report on the Effects of Gender Inequity, Stigma and Discrimination.* Cambridge: Physicians for Human Rights.

Pratten, S (2009) Critical Realism and causality: Tracing the Aristotelian Legacy. *Journal for the Theory of Social Behaviour* 39 (2) pp 189 - 218

Precht, R. (2005). *Informal settlement upgrading and low-income rental housing Impact and untapped potentials of a community-based upgrading project in Dar es Salaam, Tanzania.* Paper presented at the 3rd World Bank Urban Research Symposium on: "Land development, urban policy and poverty reduction", Brasilia, 4-6 April 2005

Proctor, J. H. (1968). The House of Chiefs and the Political Development of Botswana *Journal of Modern African Studies* 6 (1), pp. 59-79

Pugh, C. (1994). Development of housing finance and the global strategy for shelter. *Cities,* 11 (6), pp. 384–392.

QRS (2007) *Nvivo 7 Workbook. The impossible just got possible.* Southport: QRS International.

Rakodi, C., Lloyd - Jones (2002) (Ed) *Urban Livelihoods: A people Centred Approach to reducing Poverty.* London: Earthscan Publications Limited.

Ranson, R. (1991) *Healthy Housing: A Practical Guide.* London, E. and F.N. Spon on behalf of the WHO Regional Office for Europe).

Rau, B., and J. Collins. (2000) *AIDS in the Context of Development.* Paper prepared for the UNRISD Programme on Social Policy and Development. Geneva: United Nations Research Institute for Social Development.

Rex J and Moore R (1967) *Race, Conflict and Community: A Study of Sparkbrook.* London: Oxford University Press.

Rudge, J., Nicol, F. (Eds) (2000) *Cutting the Cost of Cold: Affordable Warmth for Healthier Homes*. London: E & FN Spon.

Rugalema, G. (2003) *HIV/AIDS and Land Issues: Beyond proximate linkages.* Southern Afican Regional Poverty Network. Event Papers. Available at www.sarpn.org.za/documents/e0000022/papers.php (accessed 2008)

Rushing, W. A. (1995) *The AIDS Epidemic: Social Dimensions of an infectious disease.* Boulder CO: Westview Press

Robson, E (2000): Invisible carers: young people in Zimbabwe's home based health care. *Area* 32 (1), pp. 59 - 69

Roth, M (2002) *Integrating Land Issues and Land Policy with Poverty Reduction and Rural Development in Southern Africa.* Paper prepared for the World Bank Regional Workshop on Land Issues in Africa and Middle East held in Kampala, Uganda, 29th April - 2nd May 2002. http://www.sarpn.org.za/documents/d0000021/land_Issues_Sept 2002.pdf. (Accessed 19 November, 2007)

Sachikonye, L.M (2004) *Inheriting the Earth: Land Reform in Southern Africa.* London: Catholic Institute for International Relations.

Sayer, A. (2003) *Method in Social: A Realist Approach* (2nd Edition) London: Routledge

Sayer, A. (2000) *Realism and Social Science*. London: Sage Publishing

Sayer, A. (1992) *Methods in Social Science: A realistic approach.* London: London: Routledge

Schaefer, R. T. and Lamm, R. P. (1995) (5th International Edition), *Sociology*. McGraw-Hill, Inc.

Scott, A., Ellen, J., Clum, G., & Leonard, L. (2007). HIV and housing assistance in four U.S. cities: Variations in local experience. *AIDS and Behavior* 11(Sup 2), pp.140-148

Seeley, J. (2002). *Thinking with the livelihoods framework in the context of the HIV/AIDS epidemic.* Research Paper, Livelihoods Connect, Institute of Development Studies, University of Sussex.

Selim, R (2003) Gender Dimensions of Poverty and HIV/AIDS: A statistical Review of Six Countries. *Development Policy Journal* pp. 81- 99 http://www.sarpn.org.za/documents/d0000349/UNDP_Report_7.pdf. (Accessed 19 November, 2007)

Shaw, M. (2004) Housing and public health. *Annual Review of Public Health*, 25, pp. 397 - 418.

Silverman, D. (2005) *Doing Qualitative Research.* London: Sage Publications

Siphambe, H (2003) Understanding unemployment in Botswana. *The South African Journal of Economics,* 71(3), pp. 480 - 495

Skinner, D., Tsheko, N., Mtero-Munyati, S., Segwabe, M., Chibatamoro, P., Mfecane, S., Chandiwana, B., Nkomo, N., Tlou, S. and Chitiyo, G. (2004) *Defining orphaned and vulnerable Children.* Capetown: HRSC Publishers.

Smart, R. (2003) *Policies for Orphans and Vulnerable Children: A Framework for Moving Ahead.* USAID

Smets, P (2006), Small is beautiful, but big is often the practice: housing microfinance in discussion, *Habitat International* 30 (3), pp. 595 - 613

Smith, D. M., Richman, D. D., Little, S. J. (2005) HIV superinfection . *Journal of Infectious Diseases.* 192, pp.438-444.

Smith, S., Cohen, S (2000) *Gender, Development and the HIV Epidemic.* United Nations Publication: New York. http://www.undp.org/hiv/publications/gender/gendere.htm. (Accessed 18 September 2007)

Spire, B., Duran, S., Souville, M., Leport, C., Raffi, F., and Moatti, J. P. (2002). Adherence to highly active antiretroviral therapies (HAART) in HIV-infected patients: From a predictive to a dynamic approach. *Social Science and Medicine*, 54(10), pp.1481–1496.

Stewart, K.E., Cianfrini, L.R., Walker, J.F. (2005) Stress, social support and housing are related to health status among HIV-positive persons in the Deep South of the United States. *AIDS Care.* 17(3), pp. 350 - 358.

Stillwagon, E (2002) HIV/AIDS in Africa: Fertile Terrain. *Journal of Development Studies* 38, pp.1-22

Stokes, C. S. (2003). *Measuring impacts of HIV/AIDS on rural livelihoods and food security.* Rome: Population and Development Service, FAO.

Stren, R.E. *(1990)* Urban housing in Africa: the changing role of government policy. In P. Amis, P. and Lloyd, P. (Eds) *Housing Africa's Urban Poor, pp.* 35-54. Manchester: Manchester University Press.

Surratt, H. L., and Inciardi, J. A. (2004). HIV risk, seropositivity and predictors of infection among homeless and non-homeless women sex workers in Miami, Florida, USA. *AIDS Care*, 16, pp. 594–604

Sweetman, C. (2002) *Gender, Development and Poverty* (Eds) Oxford: Oxfam

Szreter, S (1999) Rapid economic growth and 'the four Ds' of disruption, deprivation, disease and death: public health lessons from nineteenth-century Britain for twenty-first-century China? *Tropical Medicine and International Health* 4 (2), pp.146 -152. available at http://www3.interscience.wiley.com/cgi-bin/fulltext/120855511/PDFSTART. (Accessed 04 November, 2009).

Taylor, I (2003) As good as it gets? Botswana's Democratic Development. In Melber, H (Ed.), *Limits to Liberation in Southern Africa: The unfinished business of democratic consolidation.* pp. 72-92 Cape Town: Human Science Research Council.

Tembo, E. and Simela, J. 2004. *Improving Land Information Management in tribal lands of Botswana.* In: Expert group meeting on secure land tenure: 'New legal frameworks and tools'. Nairobi, Kenya.

Temple, B. (2008) Narrative Analysis of Written Texts: Reflexivity in Cross Language Research. *Narrative Analysis Qualitative Research,* 8, (3) pp. 355-365.

Temple, B., & Edwards, R. (2002). Interpreters/translators and cross-language research: Reflexivity and border crossings. *International Journal of Qualitative Methods,* 1 (2), Article 1. Available at http://www.ualberta.ca/~ijqm/ (Accessed 14 July, 2009)

The Botswana Gazette (21 January 2010), *Men sabotage HIV/AIDS Campaigns in Botswana?* Newspaper article: Available at http://www.gazettebw.com/index.php?option=com_content&view=article&id=5172: men-sabotage-hivaids-campaigns-in-botswana&catid=15:editorial&Itemid=2 (accessed on 26th March 2010)

The Lancet (2005) South Africa needs to face the truth about HIV mortality. 365 (9459): pp546. Available at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)17918-5/fulltext? (Accessed 27 September, 2010)

Thomson, H. Petticrew, M. Morrison, D. (2001) Health effects of housing improvement:systematic review of intervention studies. *BMJ* (323), pp.187–90.

Thye, Y. P., Templeton, M. R. and Ali, M (2009) *Pit Latrine Emptying: Technologies, Challenges and Solutions.* EWB-UK Research Conference 2009 Hosted by The Royal Academy of Engineering February 20, 2009.

Tlou, D (2001) *Women, The Girl Child and HIV/AIDS.* Unpublished Paper, Available at http://www.un.org/womenwatch/daw/csw/tlou2001.htm (Accessed 06 November 2007)

Tomlinson, R (2001) Housing Policy in a context of HIV/AIDS and Globalization *International Journal of Urban and Regional Research* 25 (3), pp. 649-657

Tonwe-Gold B., Ekouevi, D.K., Viho, I., Amani-Bosse , C., Toure, S., et al. (2007) Antiretroviral Treatment and Prevention of Peripartum and Postnatal HIV Transmission in West Africa: Evaluation of a Two-Tiered Approach. *Public Library of Science Med* 4(8): pp1362 -1373. Available at http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0040257 (accessed June 2009)

Tripp A. M (2004) Women's Movements, Customary Law, and Land Rights in Africa: The Case of Uganda. *African Studies Quarterly,* 7 (4) pp 1-19. Available at http://www.africa.ufl.edu/asq/v7/v7i4al/htm (accessed 12 November 2007).

Trochim, W. M. K. (2006) *The research methods knowledge base.* Atomic Dog Publishing Available at: http://www.atomcdog.com/BookDetails.asp?BookEditionID=34 (accessed August 2009)

Turner, J. F. C. (1967) Barriers and channels for housing development in modernising countries, *Journal of the American Institute of Planners*, (33), pp. 167 - 181.

Turner, J. F. C. (1983). From central provision to local enablement, new directions for housing policies. *Habitat International*, 7 (5/6), pp. 207-210.

Twinn, S. (1997) An exploratory study examining the influence of translation on the validity and reliability of qualitative data in nursing research. *Journal of Advanced* Nursing, 26, pp. 418 - 423

UNAIDS and National AIDS Coordinating Agency (2010). *Progress Report of the National Response to the 2001 Declaration of Commitment on HIV and AIDS: Botswana Country Report 2010.* Gaborone: Government Printers

UNAIDS (2010). *Report on the global AIDS epidemic.* Geneva, UNAIDS.

UNAIDS (2008a). *Report on the global AIDS epidemic.* Geneva, UNAIDS.

UNAIDS. (2008b). *Government of Botswana Country Report. Progress Report of the National Response to the UNGASS Declaration of Commitment on HIV/AIDS.* United Nations General Assembly Special Session on HIV/AIDS, December 2007.

UNAIDS (2007). *New Data on Circumsision and HIV prevention: Policy and Programme Implications.* Geneva, UNAIDS. Available at http://data.unaids.org/pub/Report/2007/mc_recommendations_en.pdf. (Accessed: 23rd April, 2010)

UNAIDS (2006). AIDS epidemic update: Special report on HIV/AIDS. Geneva, UNAIDS.

UNAIDS (2005). *United Nations Work Plan on Male Circumcision and HIV.* Geneva, UNAIDS.

UNAIDS (2005) Operational *Guide on Gender and HIV/AIDS: A Rights-Based Approach.* Amsterdam: KIT Publishers

UNAIDS (2004). *Report on the global AIDS epidemic.* Geneva, UNAIDS.

UN-Habitat, (2003). *The challenge of slums: global report on Human settlements.* London: Earthscan.

United Nations (1995), *The Copenhagen Declaration and Programme of Action: World Summit for Social Development 6-12 March 1995*, New York: United Nations Department of Publication. Available at http://www.un-documents.net/poa-wssd.htm (accessed June 15th, 2008)

United Nations Centre for Human Settlements (1996) *An Urbanising World: Global Report on Human Settlement.* Oxford: Oxford University Press

United Nations Centre for Human Settlements (1991) *Integrating housing finance in the national finance systems of developing countries: Exploring the potentials and the problems.* Nairobi: UNCHS.

United Nations (2005) *Population, Development and HIV/AIDS with Particular Emphasis on Poverty:* The Concise Report. United Nations Publication: New York.

United Nations Development Programme (2002) *HIV/AIDS and Poverty Reduction Strategies: A Policy Note.* New York: UNDP

United Nations Development Programme (2000) *Botswana Human Development Report: Towards and AIDS Free Generation.* Gaborone: Petadco Printing House

United States Agency for International Development (2008) *Maximising Choice: Diverse Approaches to the Challenge of Housing Micro Finance.* Newyork:USAID

Uys, L (2002) The practice of community caregivers in home based HIV/AIDS project in South Africa. *Journal of Clinical Nursing* 11 (1), pp. 99-108

Verhasselt, Y. (1985) Editorial: Urbanisation and health in the developing world. *Social Science and Medicine.* 21(5), pp. 483

von Shirnding, Y. E. R. (1992) Editorial: Environmental health issues in the 1990s, *South African Medical Journal*, 81, pp. 536-537.

Walker, C. (2002) Ensuring women's land access. Regional Workshop on Land Issues in Africa and the Middle East, Kamapala, Uganda, April 29-May 2, 2002.

Ward, P. (Ed.). (1982). *Self-help housing: A critique.* London: Mansell.

Webb, D. (1997) *HIV and AIDS in Africa.* Bloomfontein: David Philip Publishers and University of Natal Press.

Weir, B. W., Bard, R. S., O'Brian, K., Casciato, C. J. and Stark, M. J. (2007). Uncovering patterns of HIV risk through multiple housing measures: implications for assessment and intervention. *AIDS and Behavior* 11(Sup 2), pp.S31-S44

Weiss, H. A., Quigley, M., Hayes, R. (2000) Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis. *AIDS* 14, pp. 2361-2370.

Whitehead, A., Tsikata, D (2003) Policy Discourses on Women's Land Rights in Sub Saharan Africa: The Implications of the Re-turn to the customary. *Journal of Agrarian Change* 13 (1and 2), pp. 67-112

Whitehead, C. (2000) Editorial. *Housing Studies* 15 (3), pp. 339-340

Whiteside, A. (2002) Poverty and HIV/AIDS in Africa. *Third World Quarterly* 23(2), pp. 313-332

Williams, M. (2009). Social Objects, Causality and Contingent Realism. *Journal for the Theory of Social Behaviour,* 39(1), pp.1-18.

Williams, B., Gouws, E., Lurie, M., and Crush. J. (2002) *Spaces of Vulnerability: Migration and HIV/AIDS in South Africa.* Cape Town: Southern African Migration Project. Jonathan Crush, Series Editor.

Wilkinson, D (1999) *Poor Housing and Ill Health A Summary of Research Evidence.* The Scottish Office. Housing Research Branch. Available at: http://www.scotland.gov.uk/Resource/Doc/156479/0042008.pdf (accessed 20 October, 2009)

Wolitski, R., Kidder, D. and Fenton, F. (2007). HIV, homelessness, and public health: Critical Issues and a call for increased action. *AIDS and Behaviour,* 11(Sup 2), pp. S167-S171

World Bank. *World Development Indicators* (2006). Table 2.13. Available at: http://devdata.worldbank.org/genderstats/genderRpt.asp?rpt=profile&cty=BWA,Botswana&hm=home. (Accessed October 7, 2009)

World Bank. *World Development Indicators* (1997).New York: Oxford University Press

World Bank, (1993) *Housing: Enabling Markets to Work.* Washington, DC: The World Bank

World Health Organisation (2009). *Women and Health: Today's evidence, tomorrow's agenda* Denmark: World Health Organization.

World Health Organisation (2003). *Social Determinants of Health: The Solid Facts 2nd edition.* Denmark: World Health Organization.

World Health Organisation (1961) *The Public Health Aspects of Housing,* Technical Report No. 225, Geneva: World Health Organisation.

World Health Organisation (1948) Cited in WHO, 1961: *The Public Health Aspects of Housing,* Technical Report No. 225. Geneva: World Health Organisation.

Yeboah, I. E. A (2005) Housing the urban poor in twenty-first century Sub Saharan Africa. Policy mismatch and way foward for Ghana. *GeoJournal* 62, pp. 147 -161

Yeung, W. H (1997) Critical realism and realist research in human geography: A method or a philosophy in search of a method? *Progress in Human Geography* 21 (1) pp. 51-74.

Yin, R. (1994). *Case study research: Design and methods* (2nd Ed.). Beverly Hills, CA: Sage Publishing.

Zimba, E and Mcinerney, P (2001): The knowledge and practices of primary caregivers regarding home-based care of children in Blantyre, Malawi. *Curationis* 24 (3), pp. 83-91

Zwi, A., Mills, A. (1995) Health policy in less developed countries. *Journal of International Development* 7(3), pp. 299 - 347.

APPENDICES

APPENDIX A

LETTER ASKING FOR PERMISSION TO DO RESEARCH IN BOTSWANA

P.O. Box 70410
Gaborone
Botswana

11 July, 2007

The Permanent Secretary
Ministry of Lands and Housing
P/Bag 00434
Gaborone
Botswana

RE: APPLICATION FOR THE RESEARCH PERMIT

Dear Sir/Madam

This serves as a request to carry out a study within the areas that fall within your Ministry.

I am a Motswana PhD student at Cardiff University and would be doing my research to fulfil the requirements of the programme hence this request.

Enclosed are the following:

1. Research permit application form
2. Research proposal
3. Curriculum vitae
4. Letter of research sponsorship

Thank you in advance for anticipated cooperation.

Kelebogile Kgosi (Mrs)

APPENDIX B

RESEARCH APPLICATION FORM

REPUBLIC OF BOTSWANA

Research Application Form

Two copies of this form should be completed and signed by the applicant who wishes to obtain a permit for conducting research in the Republic of Botswana, and sent to the Permanent Secretary of the relevant Ministry, (see Guidelines for Addresses). These forms should not be submitted unless the *Guidelines for Research* have been carefully studied. A copy of any project proposal submitted to funding agencies must accompany this application. Please refer to Annexure 1 attached to this application form.

1. (a) Title of Research:

Conceptualising HIV/AIDS as a problem in Housing Delivery in Urban Areas of Botswana: A case study of Gaborone City

(b) Disciplines involved:

- Social Services
- Housing
- Family Welfare

2. Name and Address of Applicant:

Mrs. Kelebogile Kgosi
P.O. Box 70410
Gaborone
Botswana
Telephone: (00267) 72529838

Term time Address:

Cardiff School of City and Regional Planning
Cardiff University
Glamorgan Building
King Edward VII Avenue
Cathays Park
Cardiff CF 10 3WA
Wales, UK
Telephone: (0044) 07809875359

3. **Name and address of home institutions (if any) to which you are affiliated:**

University of Botswana
Private Bag 0022
Gaborone

4. **Name and address of supervisor of research (in home country) or responsible referee.**

Referee:

Dr. L. R. Mberengwa
Department of Home Economics Education
University of Botswana
Private Bag 0022
Gaborone

Research Supervisors (abroad):

- Dr Craig Gurney
  Cardiff School of City and Regional Planning
  Cardiff University
  Glamorgan Building
  King Edward VII Avenue
  Cathays Park
  Cardiff CF 10 3WA
  Wales, UK

- Mr Neil Thomas
  Cardiff School of City and Regional Planning
  Cardiff University
  Glamorgan Building
  King Edward VII Avenue
  Cathays Park
  Cardiff CF 10 3WA
  Wales, UK

Research Plans

5 (a) Main Aims (general)

The primary aims of this research are twofold: Firstly is to analyse the impact which HIV/AIDS has on housing for the poor and the low income people in Gaborone City (an urban area in Botswana); through exploration of housing related problems and constraints faced by the poor people directly affected by HIV/AIDS as well as their response to the

difficulties and problems at individual and family level. Secondly is to analyse the intervention mechanisms planned and implemented through the national housing policy and by other housing and related stake holders in response to the housing difficulties for PPLWHA at community and national level.

(b) Objectives detailed description of issues/problems and/or topics to be investigated; relevance of the research; hypothesis etc. (attach a separate sheet if necessary).

The specific research questions of the study will be as follows:

Research question one: What are the socio-economic, environmental, and physical and health problems and difficulties experienced by the poor people living with HIV/AIDS in their housing in Gaborone?

Research question two: How do the poor people living with HIV/AIDS respond at personal level in an endeavour to cope with their housing problems and difficulties?

Research question three: What underlying factors and/or structures are apparent to the different housing stakeholders; hence having an influence in the response to the housing problems and difficulties faced by PPLWHA?

Research question four: What intervention strategies have the lands and housing policy makers and other housing stakeholders put in place in response to lands and housing?

(c) Methods and Techniques

Population and Sample

The population of the proposed study will be representatives of the groups outlined below;

- Poor people living with HIV/AIDS (Directly affected)
- Poor people indirectly affected by HIV/AIDS
- Housing finance providers
- Lands and Housing policy makers
- Housing and related service providers (governmental, NGOs and Private providers)

Research Methods

The study will use qualitative data collected using the methods outlined below;

Primary data

In depth interviews will be carried out to collect qualitative data from individuals both directly and indirectly affected by HIV/AIDS; Lands and Housing policy makers,

housing finance and mortgage providers and the housing service providers. This will help to map out the trends in demand, accessibility and affordability of housing and related services for the PPLWHA. The sample population will be derived from Gaborone, the capital city of Botswana, where all the people and groups to be included in the sample population can be accesses in a less costly manner.

Secondary data

Demographic data, agency reports and newspaper articles will all be useful secondary data sources for additional information. Existing data from National AIDS Coordinating Agency (NACA), Central Statistics Office and the National records and archives will be utilised for this purpose.

7. **Name and address of financial sponsor(s) of the research (if appropriate):**

Office of Staff Development and Training
University of Botswana
P/Bag 0022
Gaborone

E-mail address – Training@ub.bw

8. **Has funding already been obtained?** Granted and not obtained as yet.

   (a) **If yes, please state the total amount granted, and the name and address of the funding agency.**

   (b) **If no, what steps are being taken to ensure sufficient funding?**

   The study is under the sponsorship of the University of Botswana and has guaranteed research funds to meet the research needs whenever needed. Please refer to the attached letter on sponsorship.

9. **If you have previously done research in Botswana please give details of the research.** No prior study done in Botswana

10. **Name and address of institution in Botswana to which the researcher is to be affiliated.** N/A

11. **Details of Botswana - based personnel that will be involved (names, functions, qualifications).** N/A

12. **Places in Botswana where the research is to be conducted**

Gaborone

13. **Proposed time - schedule for the research:**

October 2006 to September 2010

14. Plans for dissemination of research findings:

The findings will be compiled into a PhD Thesis which will be available for photocopying and for inter-library loan, and made available to outside organisations, if accepted.

15. How are the research findings going to be used in the home country?

It is anticipated that the findings of this research will contribute to the much need literature on HIV/AIDS and Housing in Botswana. The results are aimed to help in making an informed contribution in the policy decisions aimed to help counteract the impact brought about by the epidemic in housing delivery in Botswana.

16. Any other information. None

17. Signature of Applicant:

.....

18. Date: 12 July 2007.

APPENDIX C

RESEARCH PERMIT APPROVAL

TELEPHONE: + (267) 3904223
TELEGRAMS: MERAFE
FAX: + (267) 3911591/3904826

Republic of Botswana

MINSTRY OF LANDS AND HOUSING
PRIVATE BAG 00434
GABORONE
BOTSWANA

CLH 1/19/1 I (28)

14th August 2007

Ms K. Kgosi
P.O. Box 70410
GABORONE

Dear Madam

RE: APPLICATION FOR RESEARCH PERMIT

I refer to your application for a research permit to conduct a study entitled "Conceptualising HIV/AIDS as a problem in housing delivery in urban areas of Botswana – A case of Gaborone City".

Approval is granted. We request that upon completion of the research study a copy of the dissertation be submitted to the Ministry.

Good luck

Yours faithfully

D. M. Dumedisang
FOR PERMANENT SECRETARY

cc. Director of Housing

DMD/sanon: permission for research Kgosi

APPENDIX D

SAMPLE LETTER ASKING FOR PERMISSION FOR THE STUDY FROM DIFFERENT ORGANISATIONS

P.O. Box 70410
U.B Post Office
Gaborone
E-Mail kgosik@cardiff.ac.uk
ntukekgosi@hotmail.com
Cell No: 72529838

29th July 2008

The Director
.....
P.O. Box .....
Gaborone

RE: REQUEST TO CARRYOUT RESEARCH IN YOUR ORGANISATION

Dear Sir/Madam

I am a lecturer at the University of Botswana in the Faculty of Education and currently on study leave; studying for a PhD in Cardiff University School of City and Regional Planning under the supervision of Dr. Craig Gurney and Mr. Neil Thomas.

I am currently doing research entitled "**Conceptualizing HIV/AIDS as a problem of lands and housing in urban areas of Botswana: A case study of Gaborone City".** The research questions are designed to, for example: synthesise the impact of the HIV/AIDS epidemic on service delivery for lands and housing producers and consumers as well as mortgage finance providers and assess how they (the producers/suppliers and the consumers) in turn responded to the effects of the HIV/AIDS epidemic. The research also aims to analyze how the epidemic have impacted on the aims of the national lands and housing policies as well as on the different key lands and housing gate keepers; and how the land and housing policies in turn have responded to the crisis brought upon by the epidemic in order to help people directly affected with HIV/AIDS with their accommodation

In order to succeed on my research endeavours, it will be essential that I gain access to the research site; especially permission and support for a programme of interviews with organizations that offer support to people who are directly affected by HIV/AIDS epidemic. Therefore, I am

seeking permission and support for a programme of interviews with the relevant office bearers and key individuals within your organization. I will also appreciate it if you could assist with connecting me with people who are directly affected with HIV/AIDS and may be willing to participate in a programme of interviews.

My study is primarily academic although it might be of interest to policy makers therefore subject to the normal requirements of publications in a thesis and possible academic papers.

Any data which you provide will be treated in strict confidence and will only be used for the purpose of my research. This means that where appropriate any quotes from you will be anonymous to ensure that you cannot be identified. I would be grateful if you could kindly accord necessary permission for the purpose of the study and ensure that I would obtain the required assistance.

Please Note: the actual research survey will be taking place until end of September 2008.

Thank you in advance for anticipated cooperation.

Kelebogile Kgosi

……...

PhD. Researcher
School of City and Regional Planning
Cardiff University. Cardiff, Wales, UK.

APPENDIX E

INTERVIEW CONSENT FORM

A note to the interviewees:

Thank you for volunteering to participate in this interview.

Please note the following:

1. The main purpose of this interview is to solicit for information from people who are indirectly affected by HIV/AIDS on their experiences regarding issues specified in the interview questions.
2. The interview is for academic purposes only and has been designed in such a way that no individual will be identified with specific responses. The information that will be provided in this interview will remain confidential and anonymous
3. I reckon the interview will take about 45-60 minutes.
4. Your participation in this interview is voluntary. You may quit the interview at any point if you feel uncomfortable with it.

Thank you for your patience in participating in this interview. To acknowledge your understanding of the purpose of the interview and willingness to participate in this interview, please sign the consent on the space below. Your signature indicates that you have been informed about the conditions and safeguards of this interview.

CONSENT

Interviewee:

Name of Organisation.....

Signature.....Surname.....Initials.....Date.....

E-mail address.....

Address.....
.....

Interviewer:

Signature.....Surname...**Kgosi....** Initials...**K.....**Date.....

E-mail address.....kgosik@cardiff.ac.uk

APPENDIX F

INTERVIEW GUIDE FOR POOR PEOPLE LIVING WITH HIV/AIDS

The questions below will be administered to the PPLWHA in order to achieve research questions 1 and 2 below.

Research question one: What are the socio-economic, environmental, and physical and health problems and difficulties experienced by the poor people living with HIV/AIDS in their housing in Gaborone?

Research question two: How do the poor people living with HIV/AIDS respond at personal level in an endeavour to cope with their housing problems and difficulties?

PART A: INTRODUCTION

1. Introduce yourself and tell me about your place of residence (land and house that you are staying in)
    a. Gender
    b. Marital status
    c. Employment status
    d. Sources and level of income
    e. Education level
    f. Dependents if any and their relationship to you
    g. Do you know your HIV status?
    h. Are you on Anti-retro viral therapy (ARV's)
    i. Do you belong to any HIV/AIDS support group?

2. Introduce your place of accommodation
    a. Tenure type
        i. Type of property

        a. Description of rooms
    ii. Who is landlord?
    iii. Rent price/cost?
    iv. Any other households in same yard?
        a. How many adults?
        b. How many children?
b. Description of property
c. Length of time you stayed here

PART B: HEALTH AND ACCESS TO LANDS AND HOUSING MARKET

3. How long have you had this piece of land?
    a. Describe the process you went through in order to get the property.
4. Has your health status been an issue when arranging for your land? Elaborate.
5. Were you required to disclose your health status to your property providers? Please give the details.
6. What is your experience and opinion on access to land?
7. Have you personally experienced any discrimination and/or stigma upon acquisition of your property? Please give details.

PART C: LANDS AND HOUSING COSTS

PROPERTY COST

(If the consumer owns the property, go to question no 8 but if they only have undeveloped plot start at no 11.)

8. How do you finance this property?
    a. Did you take out a loan?
        i. How; with which financial provider?
        ii. When?
        iii. Can you describe the process of loan acquisition?
    b. Are you still paying for the loan you took for the property?
        i. Tell me more about the challenges you face in the repayments of the property loan.

c. Did you use this property as security against the loan you took out? Why?

9. Did you take insurance for your mortgage? Tell me more about it.
10. What is your opinion on the lands and housing costs for vulnerable people in Botswana? Why do you say that?
11. Do you have any challenges in paying for your accommodation?
    a. What challenge and why?
    b. How do you cope with the challenge, formally and informally?
    c. Tell me more about your coping strategy on housing payments.
    d. What will you want to see done to help people in your situation?
12. Do you find your health status influencing the affordability of your housing? How and why?
13. Do you get any government assistance for your cost of living?
    a. Food basket?
    b. Housing subsidies? Please provide some details.
14. Is there any other place or organisation that you know that provides assistance or schemes that deal with housing issues for vulnerable groups of people locally?
    a. In what ways?
    b. Have they assisted you with housing costs? How?
    c. Give your opinion/perception about such organisation.
15. In what ways do you think your health has had an impact on your housing situation? What is your opinion on that?
16. What's your opinion on setting up accommodation for people who are terminally ill in one location?

ACCESS TO FINANCE

17. How did you finance the initial acquisition for your land or housing?
    a. Describe the process you went through in order to get the finance.
    b. Were there any challenges faced at the time? What are your experiences?
18. Has your health status been an issue when arranging for your land or housing finance? Please give some details.
19. Were you required to disclose your health status to your financial providers? Elaborate
20. Was there any kind of special provisions or help that you were offered due to your health status? Elaborate.

21. What is your experience and opinion on stigma and access to land and housing finance?
22. Discuss how you manage the financial costs of your property, formally and informally.

SECURITY OF TENURE

23. What is your opinion on the security against loss of your housing property rights to your health status??
24. Do you feel vulnerable to losing your property? Why?
25. What have you put in place to protect your property from potential loss could any eventualities happen? Elaborate.
26. What is your opinion on the inheritance of your property?
    a. Have you made any arrangements for the inheritance of your property? How and why?
27. Have you had any experience on the following:
    a. Property grabbing?
    b. Property disinheritance?
        i. How did it come about, give the details surrounding the event.
        ii. How did you, or may deal with it?
        iii. What is your opinion/perception about them?
        iv. What do you think need to be done about these? By who? And why?

PART D: CONCLUSION

28. Lastly, do you have anything to tell me about housing and HIV/ AIDS apart from what we discussed?
    a. What would you like to see done to help people directly affected by HIV/AIDS?
    b. What needs to change? Why?
    c. What difference will that make?
29. Do you have any questions about or related **to housing and HIV/ AIDS for me?**

Thank you!

APPENDIX G

INTERVIEW GUIDE FOR HOUSING SERVICE PROVIDERS

The questions below will be administered to the lands and housing producers as well as other housing related service providers in order to answer research questions 3 and 4 below.

Research question three: What underlying factors and/or structures are apparent to the different housing stakeholders; hence having an influence in the response to the housing problems and difficulties faced by PPLWHA?

Research question four: What intervention strategies have the lands and housing policy makers and other housing stakeholders put in place in response to lands and housing?

PART A: GENERAL BACKGROUND INFORMATION

1. Introduce yourself to me please: Your name, position and responsibilities in the organisation.
2. Give a brief background to your organisation.
3. What kinds of housing related services does the organisation offer to consumers?
4. Who are the main target consumers of your services?

PART B: SERVICE NEED, SUPPLY AND DEMAND

5. What kinds of housing related services do your offer to the consumers?
6. Give a highlight on the general demand of your services?
7. According to the socio-economic categories, which group of consumers demand the services most?
8. Have there been any significant changes on the demand of your services in recent years. What has changed? Elaborate.
9. What could be the possible causes?
10. What are your views on how HIV/AIDS epidemic impacted on the demand of your services?
    a. On the organisation
    b. On the consumers

11. What intervention/strategies (if any) are planned and or implemented to adapt your services to the impact of HIV/AIDS?
    a. Short-term
    b. Medium term
    c. Long term
12. Are these intervention strategies effective and working as planned? Explain further?
13. Do you get any support from the Government's national policy to assist in the strategies of your organisation?
14. Is there anything else besides HIV/AIDS epidemic that may be a contributing factor or exacerbating the problems of demand of your services?
    a. Socio-economic
    b. Cultural
    c. Political
    d. Legal
    e. Demographic
15. How does the organisation deal with the supply of the service to meet the demand?
16. Are the opportunities to access your service equal to every one of the potential consumers without discrimination? How do you ensure that?
17. Give a highlight on the general supply of your services in recent years.
18. Has there been a significant change on the supply of your services in recent years. How? Elaborate.
19. What could be the possible causes?
20. How has HIV/AIDS epidemic impacted on the supply for your services?
    a. On the organisation
    b. On the consumers
21. What's your opinion on affordability of your services to your potential consumers?
22. How do the vulnerable groups of people manage with the cost of your services? Elaborate.
23. Are there any potential risks that you are aware of on the supply of your services that could be attributed to the HIV/AIDS epidemic that are faced by your organisation? Elaborate.
    a. Risk on the organisation
    b. Risk on the consumer
24. What interventions are planned and/or are in place to counteract the risks brought by the HIV/AIDS epidemic on your services
25. What intervention/strategies (if any) are planned and or implemented to adapt your services to the impact of HIV/AIDS?
    a. Short-term (working)
    b. Medium term
    c. Long term

26. Are these intervention strategies effective and working as planned? Explain further?
    a. Any challenges on implementation of the strategies?
    b. What are your perceptions about those strategies? Why?
    c. What do you think need to be done? By whom and why?
27. Does your organisation have any special consideration for customers who may be called 'disadvantaged or vulnerable' particularly customers with HIV/AIDS, women and the poor? In terms of being given priority in access and cost of the service. What is your opinion about the issue?
28. Do you consider gender related issues in the supply of your services? How and why?
29. Is there anything else besides HIV/AIDS epidemic that may be contributing or exacerbating the problems of supply of your services? May you discuss it further?
    a. Socio-economic (property costs, poverty, unemployment, cost of living)?
    b. Cultural (norms, values, beliefs, traditions)?
    c. Political?
    d. Legal (legislation, rights)?

PART C: IMPACT ON POLICIES FOR THE ORGANISATION

30. How has the HIV/AIDS epidemic impacted on the organisation's local policies in terms of;
    a. Rights of the consumers?
        i. Rights to own (access)
        ii. Rights to use/entitlements
        iii. Inheritance rights
    b. Tenure security?
31. Have the organisation adapted any of its housing related services and policies to accommodate HIV/AIDS epidemic? Elaborate considering what have been done and why.
32. What intervention/strategies (if any) are planned and or implemented to adapt your services to the impact of HIV/AIDS? What are they?
33. Do you get any support and or assistance from the Government's national policy to assist in the strategies of your organisation?
    a. What kind of support if any?
    b. Any challenges with the support provided?
    c. What are your perceptions about that support? Why?
    d. What do you think need to be done? By whom and why

PART D: CONCLUSION

34. Lastly, do you have anything to tell me about lands or housing policy and HIV/ AIDS apart from what we discussed?
    a. What would you like to see done to help vulnerable people?
    b. What needs to change?
    c. What difference will that make
35. Do you have any questions about or related to lands and housing and HIV/ AIDS for me?

Thank you!

APPENDIX H

INTERVIEW GUIDE FOR HOUSING POLICY MAKERS

The questions below will be administered to the lands and housing policy makers in order to research questions 3 and 4.

Research question three: What underlying factors and/or structures are apparent to the different housing stakeholders; hence having an influence in the response to the housing problems and difficulties faced by PPLWHA?

Research question four: What intervention strategies have the lands and housing policy makers and other housing stakeholders put in place in response to lands and housing?

PART A: GENERAL BACKGROUND INFORMATION

1. Introduce yourself to me please: Your name, position and responsibilities in the department.
2. Give a brief background to your Department.
3. What are the responsibilities of your Department; in terms of lands/housing and related policies?
4. What kind of housing related services does the Department offer to the people?

PART B: IMPACT OF HIV/AIDS ON POLICY AIMS

5. Give a brief outline of the department's policy aims related to lands and housing the nation.
6. What has been the major focus of the land's policy?
7. Have there been any significant changes on the implementation of the policy aims in recent years. What has changed? Elaborate.
8. In general, what are your views on the impact of HIV/AIDS epidemic on your policy aims?
9. Specifically, which areas of your policy aims have been affected more by the impact of HIV/AIDS and how are you responding to them?
10. Are there any potential risks or negative impacts that you are aware that could be attributed to the HIV/AIDS epidemic that are faced by your department? Elaborate.
11. What interventions are planned and/or are in place to counteract the risks brought by the HIV/AIDS epidemic on your services? What is their progress so far?
12. Is there any specific policy aims designed to address the lands or housing needs of vulnerable groups of people including those with HIV/AIDS?

13. Does your organisation have any special consideration for customers who may be called 'disadvantaged or vulnerable' particularly customers with HIV/AIDS, women and the poor? In terms of being given priority in access and cost of the service. What is your opinion about the issue?
14. In terms of subsidies and related assistance to vulnerable groups of people, what do the policies have on offer for,
    a. Disadvantaged groups of people especially those directly affected by HIV/AIDS?
    b. Housing producers and other stake holders?
15. As the main governing body, do your department collaborate with other stakeholders on issues related to housing vulnerable people? What do you do and why?
16. How does your office monitor that other stakeholders provide necessary assistance of housing related services to the vulnerable groups of people.
17. What intervention/strategies (if any) are planned and or implemented to adapt the policy to counteract the impact of HIV/AIDS?
    a. Short-term
    b. Medium term
    c. Long term
18. Are these intervention strategies effective and working as planned? Comment on the status and progress of those interventions?
19. Is there anything else besides HIV/AIDS epidemic that may be a contributing factor or exacerbating the problems of demand of your services?
    a. Socio-economic
    b. Cultural
    c. Political
    d. Legal
    e. Demographic
20. Does your organisation have any special consideration for customers who may be called 'disadvantaged or vulnerable' particularly customers with HIV/AIDS, women and the poor? In terms of being given priority in access and cost of the service. What is your opinion about the issue?
21. Do you consider gender related issues in the supply of your services? How and why?

PART C: IMPACT ON PROPERTY RIGHTS AND SECURITY OF TENURE

22. HIV/AIDS epidemic has had an impact on the housing and land rights of the particular groups of people more than for others? Which groups of people does your Department address as the more vulnerable, and why?
23. What's your opinion on the impact of HIV/AIDS on the following:

a. Rights to own (access)?
b. Rights to use/entitlements?
c. Inheritance rights?
d. Tenure security?

24. What does the policy have, in terms of strategies, programmes for consumers who are living with HIV/AIDS in terms of ;
    a. Rights to own (access)?
    b. Rights to use/entitlements?
    c. Inheritance rights?
    d. Tenure security?
25. What does the policy have, in terms of strategies, programmes for consumers who are directly affected in terms of ;
    a. Rights to own (access)?
    b. Rights to use/entitlements?
    c. Inheritance rights?
    d. Tenure security?
26. How has the policy been adapted generally to accommodate the impact caused by HIV/AIDS epidemic on lands and housing rights of vulnerable people? Elaborate.
27. What intervention/strategies (if any) are planned and or implemented to adapt your services to the impact of HIV/AIDS on the security of tenure?
    a. What is their current status so far?
    b. Any challenges in their implementation? What, how do you do to counteract?
    c. What's your opinion about those strategies? Why do you think so

PART D: CONCLUSION

28. Lastly, do you have anything to tell me about lands or housing policy and HIV/ AIDS apart from what we discussed?
    d. What would you like to see done to help vulnerable people?
    e. What needs to change?
    f. What difference will that make
29. Do you have any questions about or related to lands and housing and HIV/ AIDS for me?

Thank you!