More than just a roof over my head: Housing for People Living with HIV/AIDS around the World.
The International AIDS Housing Roundtable (IAHR) is a forum for discussion of issues pertaining to housing instability and HIV and the provision of appropriate housing for people living with HIV and AIDS; the Roundtable is sponsored by the United States-based National AIDS Housing Coalition. The Roundtable is intended to promote international dialogue toward the development and implementation of public policies that recognize the critical role of housing both in the prevention of HIV transmission and in the care of people who are living with HIV and AIDS. Topics related to housing stability and HIV include but are not limited to slums, property and inheritance rights, mobility, and migration. To join the Roundtable, visit http://groups.yahoo.com/group/iahr/join and follow the instructions.

The National AIDS Housing Coalition (NAHC) envisions an international community where housing is a human right and HIV disease ends. Housing clearly improves health outcomes of those living with HIV disease and reduces the number of new HIV infections. The end of HIV/AIDS critically depends on an end to poverty, stigma, housing instability, and homelessness.

The National AIDS Housing Coalition works to end the HIV/AIDS epidemic by ensuring that persons living with HIV/AIDS have quality, affordable, and appropriate housing. NAHC accomplishes this goal through policy and resource advocacy, the fostering and dissemination of research, and the convening of leaders to affect change at the local, national, and international levels.

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Preface

The following document examines the relationship between HIV/AIDS and housing instability in various communities, cities, and nations across the globe. The majority of the text was provided by advocates working on the ground in their communities and affiliated with the National AIDS Housing Coalition through the International AIDS Housing Roundtable; their organizations are cited and their testimonies were supplemented by data and information from UNAIDS, UN-Habitat, as well as other institutions and peer-reviewed articles. Names are withheld from personal testimony to protect confidentiality.

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More than just a Roof Over my Head:
Housing for People Living with HIV/AIDS around the World
Introduction

The purpose of this document is to examine the relationship between HIV/AIDS and housing instability. Adequate housing is a human right and a necessary foundation to fulfill other rights and to enjoy a decent quality of life. While poverty is linked to poorer health outcomes and creates an environment of risk across the globe, HIV infection is prevalent among all socioeconomic classes, and HIV/AIDS exacerbates poverty and inequalities across the board. HIV prevalence in urban areas is 1.7 times the prevalence in rural areas, while HIV is most prevalent in the poorest region of the world: sub-Saharan Africa, where HIV/AIDS is most experienced in rural areas and where access to information and health services is limited.

Approximately 3.49 billion people (50.6% of the world’s population) live in urban areas; one third of these residents are poor, while almost a quarter (827.6 million people) live in slums. In sub-Saharan Africa, 61.7% of the urban population lives in slums, followed by South-Eastern Asia (31%), Latin America and the Caribbean (23.5%), and North Africa (13.3%). Slums are characterized by poor sanitation and hygiene, unsafe water supply, malnutrition, insecure land tenure, and lack of access to basic health, transportation, and other public services. These conditions increase the risk of HIV infection and poor health outcomes related to AIDS-related complications and mortality.

Regardless of socioeconomic status, HIV/AIDS is inextricably linked to stigma and discrimination, which can impact family and community support, income and employment, and housing security. Forced evictions and job terminations due to discovery of HIV status not only violate human rights but also disrupt access to nutrition and medical regimes, which ultimately threatens the health and well-being of HIV-positive individuals. The United Nations Development Program explains, “The devastation caused by HIV/AIDS is unique because it is depriving families, communities and entire nations of their young and most productive people. The epidemic is deepening poverty, reversing human development achievements, worsening gender inequalities, eroding the ability of governments to maintain essential services, reducing labour productivity and supply, and putting a brake on economic growth. The worsening conditions in turn make people and households even more at risk of, or vulnerable to, the epidemic, and sabotages global and national efforts to improve access to treatment and care. This cycle must be broken to ensure a sustainable solution to the HIV/AIDS crisis.”

Gender inequality and homophobia impact both housing security and HIV/AIDS risk, creating a double vulnerability for HIV-positive women and sexual minorities. Intimate partner violence and gender discrimination limit the ability of women to protect themselves against HIV/AIDS. The diminished likelihood of negotiating condom use, the limited capacity to make their own sexual decisions, and the general threat of violence has led to increased infection rates among women, who represent 58% of all HIV cases. The majority of the world’s poor are women, and female-headed households suffer disproportionately from inadequate housing. Women’s property and inheritance rights are often ignored, and they may be excluded from wills, housing financing, and other mechanisms that ensure their housing security. In many cases widows are evicted from their homes by their in-laws following their husbands’ deaths from AIDS-related causes. As the Centre on Housing Rights and Evictions (COHRE) explains, “Gender discriminatory norms and traditional practices which limit or preclude women’s access to housing, land and property, both generate and sustain the dire circumstances which underlie women’s disproportionate susceptibility to HIV infection.”
Men who have sex with men (MSM) are the group most at-risk of HIV infection across the globe, largely due to discriminatory laws and social stigma that drive MSM underground and out of reach from prevention, treatment, and care efforts. Homophobia also puts MSM at risk of forced evictions from family homes and exclusion from housing services, which makes MSM disproportionately represented among homeless populations.

Prison, migrant, and mobile populations have also been increasingly identified as vulnerable to HIV infection due to increased risk behaviors, stigma, and discrimination. As UNAIDS explained in its background paper for the 24th Programme Coordinating Board meeting in 2009, “The conditions under which people move—and the ways they are treated throughout the migration cycle—pre-departure, in transit, at destinations and upon return—that most determine their vulnerabilities, which in turn affect their risks of acquiring HIV.” Prisons are high-risk environments for HIV transmission not only for the prevalence of risky behaviors but also because of the prisons themselves, which are often overcrowded and limit access to adequate nutrition and healthcare.

Rooftops Canada asserts that “Efforts to ensure adequate housing for urban slum dwellers – to secure tenure, inheritance rights, adequate water and sanitation, economic development – address many of the vulnerabilities that relate to HIV/AIDS.” For women, sexual minorities, and other vulnerable populations, the realization of housing rights may mitigate the impact of HIV/AIDS by combating stigma and discrimination, reducing dependency, and enhancing personal autonomy and economic security. Housing security eases the burden of care and support and optimizes health outcomes.

There is an urgent need for dialogue on poverty, housing instability, slums, gender-based property and inheritance rights, the economic impact of stigma and discrimination, mobility and migration, and food security and hunger as critical issues in global policy and program responses to the continuing AIDS crisis. International HIV/AIDS and housing activists urge our colleagues to unite to demand that adequate housing be an integral part of any HIV/AIDS public policy development and that housing be treated as an urgent matter.

Sources:

The Global Forum on MSM and HIV, Social Discrimination against Men who have Sex with Men (MSM): Implications for HIV Policy and Programs, 2010.
Montgomery, Mark R. (Population Reference Bureau), Urban Poverty and Health in Developing Countries, 2009.
UNAIDS Policy and Practice, Key Populations: Men who have Sex with Men, 2010.
WomenWatch, Gender Equality and Sustainable Urbanisation Fact Sheet, 2010.
More than just a Roof Over my Head:
Housing for People Living with HIV/AIDS around the World
Developing Countries

Latin America and the Caribbean are highly urbanized: 75% of the population – and 60% of the poor – lives in cities. Latin America is the world’s most economically unequal region. The HIV epidemic in the region is low-level and concentrated among certain populations with a regional prevalence of 0.6%.
**Belize**

**The HIV/AIDS Epidemic**

Estimates for the number of people living with HIV/AIDS (PLWHA) in Belize range from 2,200 to 5,300. The 365 new HIV cases in 2009 represent a 14.1% decrease compared with 2008 (425 cases). However, the 92 new AIDS cases in 2009 represent a 21% increase compared to the 76 new AIDS cases in 2008. 51.5% of new HIV infections occurred in women in 2009. Belize has 11 treatment sites, one within the Belize Central Prison. About 61.3% of all people with advanced HIV infection are receiving antiretroviral (ARV) treatment in 2009, an increase from 49% in 2008.

**The Housing Crisis**

Belize City suffers from old, insect-infected housing stock. Substandard housing has been erected in the slum areas surrounding the capital city. Because Belize City and most of the coastline have been built on swampland, affordable housing has been both an economic and technical challenge. In rural areas, many villages suffer from inadequate housing and infrastructure. Immigrants from neighboring Central American countries live in substandard housing on the outskirts of cities and towns. The housing needs for PLWHA has never been officially acknowledged by either the housing or HIV/AIDS advocacy organizations.

**Institutional Response & Solutions**

While there is no government data on the need for adequate housing, the government has pledged to build 10,000 houses over a five-year period. The United Belize Advocacy Movement (UNIBAM), which works to reduce stigma against lesbian, gay, bisexual, transgender, and intersex (LGBTI) communities and PLWHA through educational and media activities, advocacy, and HIV/AIDS prevention programs, has had homeless clients. One client became homeless after losing his job, where he had persistently been mistreated by fellow employees. Another client who approached UNIBAM was a homeless substance user with a physical disability. However, there was little UNIBAM could do but provide food, support, and information.

More research needs to be conducted in Belize regarding the housing needs of PLWHA, particularly for drug users, sexual minorities, people with disabilities, immigrants, and others vulnerable to stigma and discrimination in order to make the issue visible at the policy level. Belize has been recognized by UNAIDS for its progress in realizing its national commitments to HIV/AIDS and for its multi-sectoral response, which includes the Ministries of Labor, Youth and Education. Housing for PLWHA fits into Belize’s national mitigation goals to improve integrated care, support, and treatment services and to improve policies and programs addressing the reduction of the socioeconomic impact of HIV/AIDS.

*Advocate testimony provided by Caleb Orozco of the United Belize Advocacy Movement.*

**Sources:**

Habitat for Humanity Belize, 2002.
La Paz, Bolivia

The HIV/AIDS Epidemic

Bolivia has the lowest HIV incidence rate in South America. Approximately 4,600 Bolivians are currently living with an HIV/AIDS diagnosis; 18% of this population lives in the state of La Paz. However, UNAIDS estimates that around 8,000 Bolivians are HIV-positive and unaware of their status. The epidemic is concentrated among MSM and sex workers, but it is trending toward a generalized epidemic with 50% of transmissions occurring through heterosexual contact. During the early years of the epidemic in Bolivia, the gender ratio was eight male infections for every one female infection, but this ratio is now closer to 2:1. In a seroprevalence survey carried out in Cochabamba, Bolivia (the city with the second highest HIV prevalence after La Paz), the population with the highest HIV prevalence was homeless youth living on the street.

The Housing Crisis

Bolivia is the poorest country in South America. On the human development index Bolivia ranks 113th out of 182 countries. About 63% of the Bolivian population lives in urban areas; of this group, 61% lives in slums. The population of the La Paz metropolitan area is approximately 800,000 or 9% of the national population. In La Paz a greater percentage of people live in slum conditions (64%) than the national average. These slums are characterized by a lack of access to water, sanitation, electricity, transportation, and other basic services, as well as insecure tenure. In many cases housing is informally constructed by tenants themselves, and the units are structurally insecure. The housing deficit for the country as a whole is 211,200 units; in La Paz the deficit is approximately 50,000 units.

In a survey of housing conditions of PLWHA in La Paz, results indicate that the majority of participants do not own their own homes because of reported: (1) difficulty in securing and maintaining steady employment; (2) difficulty in saving sufficient funds; and (3) difficulty in accessing credit. In this survey it was noted that the obstacle to securing adequate employment was not a consequence of low educational levels; on the contrary, 61% of respondents had a university degree, while the remaining 39% had all finished high school and attended university (though had not received a degree). The primary barrier to securing employment was the respondents’ health status, which led respondents to prefer employment close to home that did not require much physical exertion. In addition to health status, the effects of stigma and discrimination led some respondents to abandon efforts to secure steady employment and maintain a healthy lifestyle. In fact, virtually all of the respondents who had disclosed their HIV status to employers subsequently lost their jobs. Some PLWHA had been kicked out of their homes by their families when they disclosed their status. In terms of savings, respondents explained that because all available funds are prioritized for medical expenses and food, nothing is left to save. Female respondents reported lower salaries than their male counterparts, demonstrating the double burden on HIV-positive women to do more with less.

According to an advocate at National Network of People Living with HIV in Bolivia (REDBOL), homeless shelters do not take HIV into account. Yet one shelter, upon learning that a client was HIV positive, refused to provide services for the client, claiming that he was the “...HIV program’s responsibility.”
Institutional Response & Solutions

Under Bolivian Law 3729, “Law for the Protection of Human Rights and Comprehensive, Multidisciplinary Assistance for People Living with HIV/AIDS,” approved in August 2007, treatment and care for PLWHA in Bolivia is free and guaranteed by the state. The law also protects PLWHA from discrimination and guarantees them the full rights prescribed by the Constitution. Unfortunately this law does not cover all of the medications recommended for PLWHA, which become a substantial out-of-pocket expense.

The unmet need described above from the survey of PLWHA in La Paz led to the following recommendations:

- A mass education and awareness-raising campaign to combat stigma and discrimination;
- Protection against termination of employment for PLWHA;
- Inclusion of PLWHA in public policy discussions and decision-making processes concerning HIV/AIDS and human rights of PLWHA;
- Improved health coverage and access to better treatments and medications;
- Guarantee of all basic services, including transportation, for PLWHA;
- Regulation of market rates for housing, land, rental, and mortgage units and services;
- Creation of service and support organizations specifically focused on housing for PLWHA;
- Creation of a transitional housing program at the regional and national levels;
- Creation of residential programs for PLWHA; and
- Prioritization of support for women, youth, LGBTI, and other vulnerable PLWHA.

“I worked at a transnational business where I was hired for my tax and accounting skills and three university degrees. I assumed many responsibilities in a high-level administrative position until one day last year when I had health problems and was told I needed surgery. The company asked for an annual health exam, which included a clandestine HIV test. I submitted to an HIV test without my knowledge, which is illegal. The company found out that I was positive – I didn’t even know; the doctor who was performing my surgery told me. I was fired the next day. They never admitted it, but I know that it was because the lab technician told them I was positive. Now I know that there are national and international laws that protect us, but what are you going to do? I filed a complaint with the Ministry of Labor, but nothing has happened so far. I am scared to apply for jobs in other major companies because they could reject me if they find out. Despite my education, my hands are tied. I feel like my reputation is stained by this disease.”

Advocate testimony provided by Alan Octavio Vera Velasco, independent architect, and Juan Carlos Rejas of the REDBOL National Network of PLWHA – Bolivia.

Sources:

Vera Velasco, Alan Octavio, La Vivienda y el VIH/SIDA en La Paz, Bolivia, 2010.
**Santiago de Cali, Colombia**

**The HIV/AIDS Epidemic**

Around 6,000 total HIV infections have been reported in Santiago de Cali, Colombia’s third largest city. HIV prevalence in Cali is 0.07%; the epidemic is generalized with infections reported among pregnant women, sex workers, sexually transmitted infection (STI) patients, prisoners, and victims of sexual violence. The highest rate of infection is among people 25 to 39 years of age, and the infection rate is growing among women as heterosexual transmission increases. No HIV data exist for indigenous populations. A study published in 2008 of 143 HIV-positive patients in a hospital in Cali indicates a 22% prevalence of mental illness among the sample.

**The Housing Crisis**

The Municipality of Cali identified a housing deficit of approximately 67,000 units in 2000, and anecdotal data demonstrate that many people live in inadequate or unsafe conditions. The major issues are in housing mobile populations or those displaced by internal violence; 4.6 million Colombians have been displaced by internal violence since the early 1980s, surpassing the Sudan as the country with the largest displacement crisis. About 80% of displaced individuals seek refuge in urban areas and often end up in informal settlements lacking basic services. Approximately 45% of the Colombian population as a whole lives in unhealthy housing, and data show that by the end of the 1990s Colombia had a total housing deficit of in the range of 41% to 52% of total housing units.

 Colombian women are particularly vulnerable to issues of housing instability. In Colombia housing ownership is 15% higher for men than women, and 65% of the households headed by women fall under the poverty line. Poor women with HIV/AIDS living in unstable housing face barriers in obtaining sufficient resources to successfully adhere to antiretroviral therapy (ART).

**Institutional Response & Solutions**

In October 2000, the Municipality of Cali identified regularization of land tenure as a priority in its Municipal Development Plan. The goal of the project, in cooperation with the Cities Alliance, World Bank, and UN-Habitat, is to integrate informal settlements into the formal urban structure through slum upgrading programs. The project aims to regularize land tenure for 6,000 slum dwellers and to begin upgrading activities in addition to supporting the Municipality of Cali in promoting land tenure regularization. While the Ministry of Environment, Housing and Territorial Development has a program called Healthy Housing to promote sanitation services and installation, neither the Municipality of Cali nor the Ministry have recognized the particular vulnerabilities and housing needs of PLWHA.

The Latin American Network of PLWHA (Redla+) helps people to defend their housing rights and quality of life, but one advocate from Cali believes that the government must develop the political will to create housing laws specifically for PLWHA: “There is a lack of diagnosis and acknowledgement.”

Advocate testimony was provided by Oswaldo Rada of the Latin American Network of People Living with HIV/AIDS (RedLA+) and the Global Network of People Living with HIV/AIDS (GNP+.)
Sources:


Clavijo, Sergio et. al. (IADB), The Housing Market in Colombia: Socioeconomic and Financial Determinants, 2005.


UN-Habitat Colombia, Slum Upgrading and Land Tenure Regularization, 2010.

Wilson, Maya (Council on Hemispheric Affairs), Colombia: Latin America’s, if not the World’s, Capital of Internally Displaced People, 2010.

Puntarenas, Costa Rica

The HIV/AIDS Epidemic

Five hundred and eighty-two HIV/AIDS cases have been officially documented in Puntarenas, the southernmost province of Costa Rica that is predominantly rural and encompasses the majority of the country’s Pacific coastline. However, the actual number of undiagnosed HIV/AIDS cases could be as high as 6,000. The majority of HIV transmission in Costa Rica occurs through homosexual transmission with approximately seven male HIV infections for every three female HIV infections.

The majority of the country’s HIV/AIDS incidence is located in the urban areas of metropolitan San Jose and other major cities, mirroring the growing urbanization as a result of rural to urban migration. These migrant populations often reside in informal settlements on the outskirts of metropolitan areas, lacking access to basic services as well as sex education and prevention services. Since the majority of infections are concentrated in the large urban areas such as San Jose, HIV/AIDS policies and services often do not reach Puntarenas, even though Puntarenas is the province with the third highest HIV incidence rate.

Little information is known about HIV incidence among mobile populations, particularly immigrant and transit populations, who are often undocumented and do not frequent health centers. Other vulnerable groups include farmers, fishermen, and homeless people. Distrust exists among the Costa Rican population as a whole surrounding guarantees of confidentiality in health centers.

Even though PLWHA are protected from stigma and discrimination under Law 7771 (see below), there have been various reports of discrimination, often associated with homophobic attitudes, that have prevented PLWHA from accessing dental care and HIV-positive women from accessing cervical cancer prevention services. However, the most frequent type of discrimination occurs in the workplace via compulsory HIV testing, mostly in multinational companies. A positive diagnosis often leads to termination or reduction of responsibilities.

The Housing Crisis

Puntarenas is the province with the lowest human development index, highest unemployment rate, and lowest education rate. Poverty in Puntarenas is concentrated in the most populated urban centers (Barranca, Chacarita, El Viente, and Fray Casiano).

In terms of PLWHA in Puntarenas, their lack of adequate housing is a consequence of their social exclusion. Many PLWHA, in order to avoid disclosing their status, have broken their family and community ties, leaving the security of employment and family homes by moving to San Jose. Many of these people eventually become homeless or turn to drugs, both of which represent substantial barriers to regaining employment.

An HIV diagnosis is also a barrier to obtaining a housing voucher in Costa Rica. According to Law 7052, every citizen has the right to request a housing voucher. However, one requirement to accessing a voucher is providing evidence of an insurance policy from the National Institute of Insurance, which has not covered PLWHA since 1999, given the high mortality rate associated with an HIV/AIDS diagnosis.
Institutional Response & Solutions

HIV/AIDS has been identified as a national priority since 1997. Implemented initiatives to mitigate the impact of the disease include obligatory incidence reporting; the General Law on HIV/AIDS (Law 7771); sex education campaigns; the creation of the National Council on Comprehensive HIV/AIDS Care; and the guarantee of comprehensive health services with a special focus on populations at risk.

Law 7771 guarantees the human rights of PLWHA, including the prohibition of discrimination and degrading treatment, and Article 28 states that: “The state may designate the necessary resources for the creation or strengthening of shelters to care for patients that require support, according to the guidelines of the Ministry of Health. The state is authorized to support, on equal terms, non-profit private shelters that are dedicated to serving these patients.”

San Jose has two shelters for PLWHA: “Nuestra Señora del Carmen” and “Hogar de la Esperanza,” which provide shelter for 15 to 25 people each. Many of the PLWHA who frequent these shelters suffer from drug and alcohol addiction and mental illness. Other religious organizations such as “Casa Santa Clara” and “Casa de Paz Sucot Shalóm” implement strategies aimed at HIV-positive people, families affected by HIV/AIDS, HIV-positive homeless women, IDUs, and others. These strategies include soup kitchens, financial support, and transitional housing. Even though the number of PLWHA who are homeless is unknown, clearly the homeless PLWHA outnumber the spaces in existing shelters.

“I was diagnosed with HIV ten years ago, and I have been living at Casa Hogar Nuestra Señora del Carmen for two years and five months. Once I was diagnosed, I was thrown out of the house I shared with my mom. We lived in an apartment we inherited through the family, but due to various financial problems my mom sold her share and I ended up in the street. I came to live here because I didn’t have any place else to live. I consider this place my home now, because I really do have a family that supports me here. It is difficult to live somewhere that is not your own house, because we all come from different backgrounds, but at the same time it is enjoyable because we support one another and take care of each other.”

“Every day we receive phone calls from people asking if we have space for a family member, friend, or neighbor with HIV who does not have a place to live. Unfortunately, I have to tell them that we don’t have any available space, that the Casa Hogar Nuestra Señora del Carmen is full, and we can’t house any more people. In fact, we have a surplus of two or three people as it is...”

Casa Hogar Nuestra Señora del Carmen, San Jose, Costa Rica
Advocate testimony and photos provided by Juan Luis Barrantes Guzmán of the Comunidad Internacional Siloé.

Sources:

Panama

The HIV/AIDS Epidemic

Estimates of the number of PLWHA in Panama range from 16,000 to 26,000. HIV prevalence is estimated at 0.9%. For every three men infected, one woman is infected with HIV. The epidemic is concentrated in urban areas and among sex workers and MSM.

The Housing Crisis

While Panama is categorized as an upper middle-income country, it is one of the countries in the region with the highest income inequality. Of the total population, 37% live in poverty; that percentage is comprised of 65% of the rural population and 15% of the urban population. In 2005, Panama’s housing deficit was listed at 192,840 units.

Various Panamanian advocates have noted that access to housing is an obstacle for PLWHA in Panama. In order to obtain financing, banks and credit agencies ask for medical records and disqualify PLWHA because HIV is still considered to be a terminal disease. PLWHA and other persons with terminal diseases in Panama qualify for a Social Security pension; however, once one enrolls in this program, that person’s status is public for all governmental authorities and available for banks and agencies seeking personal information.

Many HIV-positive Panamanians have trouble accessing formal employment because of their health status as well as stigma and discrimination. Their lack of income, combined with family rejection and abandonment, leads many PLWHA to live in shelters specifically for HIV-positive people. Unfortunately, the demand for shelters far exceeds supply.

Institutional Response & Solutions

The Ministry of Health in collaboration with the Clinton Foundation secured its first shipment of generic antiretrovirals in 2009, which saved the state an estimated $1.8 million USD. Improving universal access to treatment prioritizes women and children.

Panama’s Ministry of Housing has prioritized various housing programs that fall under the first Millennium Development Goal of eradicating extreme poverty and hunger, including housing for indigenous populations and subsidized housing savings programs for families without access to traditional financing mechanisms, as well as the Housing Assistance Program (FASHABI), which provides emergency housing in the case of disasters, family emergencies, and extreme poverty. However, none of these programs target PLWHA.

“We face our disease living with our families who provide some support. You have little hope of obtaining our own house unless you win the lottery and you pay for it in cash!”

Advocate testimony provided by Jorge Luis Rodríguez of the Fundación PROBIDSIDA.

Sources:

Ministry of Housing of the Republic of Panama, National Housing Programs, 2010.
World Bank Indicators Database, Panama, 2009.
Saint Lucia

The HIV/AIDS Epidemic

Saint Lucia is an island state located in the Eastern Caribbean. It is a primarily rural state with a population of 170,649. HIV/AIDS in Saint Lucia is a low-prevalence epidemic concentrated among sex workers (selling sex for money, drugs, gifts, and support) and men who have sex with men and women. According to Saint Lucia’s 2010 Country Progress Report for UNGASS, “…trends in HIV transmission are linked to increased poverty and social disintegration with significantly higher levels of HIV now being identified in a number of vulnerable population groups.” The feminization of the epidemic, in which the male: female ratio has gone from 75:25 to 58:42, is attributed to the underground population of men having sex with both men and women.

There are 450 known cases of living HIV/AIDS in Saint Lucia, which translates into a prevalence rate of 0.28%, but this number is likely to be a gross underestimation due to lack of adequate data and research on HIV prevalence among the drivers of the epidemic.

The Housing Crisis

Both the number of households and urbanization rates are increasing in Saint Lucia while average household size is declining. This means that more housing units will be required as rural to urban migration continues; 38% of the population now lives in urban areas. While housing quality has generally improved over time, housing disparities continue, and housing demand for both rental and owner-occupied housing far outstrips supply. Twenty-one percent of households live below the poverty line, and very low income groups cannot afford an average two-bedroom house at market value. Housing affordability is worsening overall, and rental housing is even less affordable than owner-occupied housing. Households living in poverty have responded to this crisis by erecting informal housing; there are at least 35 squatter settlements throughout Saint Lucia, and UN-Habitat estimates the slum to urban population ratio at 12%. The annual housing need over the next ten years is estimated at 2,100 units.

The Saint Lucia National Housing Corporation is the leading producer of low-income housing. However, low-income housing represents less than 30% of all housing production, even though 70% of housing applicants are classified as low income. Other programs and projects have provided housing targeted for low-income populations, but no comprehensive strategy exists for increasing low income housing stock.

“Special Needs Housing” for the elderly and homeless is usually sponsored by non-governmental organizations and civil society organizations. The Caribbean Harm Reduction Coalition runs a shelter for HIV-positive drug users and MSM and provides outreach to homeless PLWHA to monitor medication and provide nutritional support, as well as performing general prevention and testing outreach to homeless crack cocaine users. In its recent survey of 350 homeless crack cocaine users, respondents indicated that the lack of housing stock is a major issue in obtaining affordable housing. According to the Coalition, 200 of the 450 PLWHA in Saint Lucia are either homelessness or living in unstable housing, but both funding and stigma, a not in my neighborhood mentality, are obstacles in providing housing support to this population.
In March of 2008 the Ministry of Housing, Urban Renewal and Local Government released its National Housing Policy, outlining the goals for housing development and strategies for achieving these objectives. In this document the government acknowledged the need for improved efficiency and collaboration among public and private organizations to improve housing delivery. One of the policy goals of this document is to “...promote sustainable mixed-income housing developments that meet the needs of all socio-economic groups and also takes cognizance of the needs of vulnerable groups.” However, the Ministry of Housing, Urban Renewal and Local Government has not recognized the particular housing needs of PLWHA, despite the fact that UNAIDS recognizes the link between poverty, social disintegration, and HIV transmission rates.

According to the Caribbean Harm Reduction Coalition, more funding for housing programs for vulnerable populations would help solve the housing crisis for PLWHA.

The Saint Lucia National HIV and AIDS Strategic Plan has four broad strategies:

**STRATEGY 1**: Advocacy, Policy Development
Including advocacy, policy and legislation, poverty reduction, and human rights.

**STRATEGY 2**: Comprehensive HIV and AIDS care for all people living with HIV
Including treatment, care and support; guidelines and protocols; psychosocial care; stigma and discrimination; workplace interventions; and community and health systems interventions.

**STRATEGY 3**: Preventing further transmission of HIV
Including mother to child transmission, voluntary counseling and testing, and STI interventions among targeted and vulnerable groups.

**STRATEGY 4**: Strengthening national capacity to deliver an effective, coordinated and multi-sectoral response to the epidemic.
Including research and surveillance; monitoring and evaluation; empowering the National AIDS Coordinating Council; and multi-sectoral coordination and collaboration.

In addition to these strategies, a human rights desk was established in 2007 in order to deal with HIV/AIDS-related stigma and discrimination. Individuals can file complaints; the majority of complaints filed so far relate to stigma and discrimination within households and the community.

Advocate testimony provided by Bernard Frederick and Marcus Day of the Caribbean Harm Reduction Coalition.

Sources:
Southeastern Asia has the highest number of urban poor in the world. India accounts for 17% of the global slum population and half of Asia’s HIV prevalence. The Philippines, which is expected to be 80% urbanized by 2030, has experienced a recent increase in HIV infection even though overall prevalence is low.
India

The HIV/AIDS Epidemic

India carries the largest HIV burden behind only South Africa and Nigeria; 2.27 million Indians are living with HIV/AIDS. The epidemic appears to be in decline from 0.34% prevalence in 2007 to 0.29% prevalence in 2008. The primary modes of transmission are through transactional sex, homosexual transmission, and injecting drug use (IDU). Socioeconomic vulnerability, coupled with the cultural taboo surrounding HIV/AIDS and female sexuality, has led to women’s increased vulnerability to HIV/AIDS; 90% of women who become infected are infected through their husbands or intimate sexual partners. HIV incidence is higher in cities with larger migrant populations.

Migrants and truckers have been identified as primary transmission bridge groups from the high risk groups to the general population. Short-term migrants account for nine million of the approximately 200 million migrants in India, while approximately half of the five million truckers drive long-distance routes. These working conditions and the extended separation periods make short-term migrants and long-distance truckers increasingly vulnerable to HIV transmission.

The Housing Crisis

Twenty-nine percent of India’s population is urban; of those, 55% of the urban population lives in slums. In 2007, the housing deficit in India was estimated to be 40.66 million units (24.7 million houses in urban areas and 15.95 million houses in rural areas).

Women’s property rights in India are insecure, and even more so in the context of HIV/AIDS. In the event of their husbands’ deaths, many women are forced by their in-laws to leave their marital homes, even after these women have depleted all their assets to pay for medical treatment and funeral expenses. Widows’ HIV-positive status is often used against them. Property is denied on the justification that these women will die from the disease anyway or that their positive status means that these women no longer deserve the right to own a share of family property.

Institutional Response & Solutions

India’s National AIDS Control Program (NACP) has mainstreamed HIV prevention through programs at the Ministries of Women and Child Development, Labor and Employment, Social Justice and Empowerment, Railways, Defense, Surface Transport, and Human Resource Development. Social Security support and subsidized travel have been extended to PLWHA, while the State of Orissa and the National Capital Territory of Delhi have both issued Below Poverty Line (BPL) cards to PLWHA to ensure access to free/subsidized food and housing facilities. The State of Andhra Pradesh provides a monthly pension to 40,000 PLWHA living below the poverty line and undergoing ART treatment. The Ministry of Labor’s program on HIV/AIDS aims to mitigate stigma and discrimination against PLWHA in the workplace, protect the rights and dignity, and raise awareness regarding HIV prevention.

Targeted interventions are aimed at both migrants and truckers through partnerships between the NACP and the Transport Corporation of India Foundation. Interventions aimed at contacting short-term migrants either in home or work locations originally had relatively low
impact, so the intervention was shifted to contact migrants in sex work locations and through the media, which increased coverage from 30% to 34%. Condom social marketing and mass media campaigns compose the interventions for truckers, covering 30% of the targeted population.

While HIV-positive women and widows may turn to legal means for recovering and protecting property rights, which can be quite effective, formal procedures are time consuming and expensive for both individuals and legal organizations.

Sources:
International Co-operative Alliance, Housing Co-operatives in India, 2008.
The Philippines

The HIV/AIDS Epidemic

Two HIV/AIDS cases were first recorded in the Philippines in 1984. According to the National Epidemiology Center of the Department of Health (DOH), the total number of HIV/AIDS cases over 26 years is 4,424; 3,592 are asymptomatic and 832 are AIDS cases. However, in 2008 UNAIDS estimated a higher number of cases at 8,300. A recent article in the Journal of the International AIDS Society warns that while the HIV/AIDS epidemic has been characterized as “low and slow,” given the country’s conservative culture, high circumcision rates, and low injection drug use, contrasting factors suggest that the epidemic will soon increase, given the low rates of condom usage, increasing sexual activity, the return of Filipino migrant workers from high prevalence settings, and misconceptions and lack of education regarding HIV/AIDS and how it is transmitted.

In December 2009, 125 new HIV cases were confirmed by the DOH, a staggering 232% increase compared to the same period last year (n=38 in 2008). Seventy-three percent of HIV-positive individuals are male, and sexual contact accounts for 90% of HIV transmission. The infections are concentrated among sexual workers, MSM, IDUs, and overseas contract workers.

Current trends in Philippine HIV infection are shifting to MSM and younger populations; the age range associated with the most infections has shifted from 30 to 39 years of age to 20 to 29 years of age. Infection through homosexual contact increased from 40% in 2008 to almost 70% in 2009.

The Housing Crisis

Metropolitan Manila, the main urban center of the Philippines, is composed of 15 cities and reflects the national housing situation. As in some developing countries, Metropolitan Manila as an urban center is sprawling with pockets of residential and slum communities interspersed with commercial and business districts. According to the United Nations, 11.4 million (20%) of the national urban population of 57 million (64%) is in Metropolitan Manila, and 16.5 million (30%) of that urban population are said to be living in slums. Sixty-five percent of the country’s population is urbanized with a slum to urban population rate of 44%.

According to the 2005-2010 Medium Term Philippine Development Plan (MTPDP), the country’s housing backlog is at 946,466 units, while the housing need is at 3.76 million units. The government’s goal is to provide 1.2 million units of housing, which only represents 30% of the total housing need. Meanwhile at least 21,047 families living in waterways are due for relocation. Many causes are associated with the housing shortage, including rapid urbanization and rising urban poverty; high cost of land and building materials; poor implementation of existing policy; and lack of government funds and capacity.

No existing studies document the housing situation or even the socioeconomic status of PLWHA in the Philippines. A community survey conducted among 54 PLWHA found that 64% either rent their homes or live with family and friends, while more than half of the respondents were unemployed and living below the poverty line. In the current economic climate, coupled with the debilitating effects of the disease, acquiring adequate employment to support the basic needs of shelter, food, and medicine is difficult, and many resort to staying with relatives or constructing makeshift shelters in squatter communities.
Institutional Response & Solutions

The main focus of the government is to partner with the private sector to provide the poor with shelter, while HIV/AIDS prevention focuses primarily on awareness-raising, treatment, care, and support. While there are a myriad of government agencies and civil society organizations addressing the HIV/AIDS epidemic or the housing crisis, no organization addresses the housing needs of disadvantaged groups such as the elderly, disabled, or PLWHA.

Landmark legislation advocated by civil society organizations to ensure housing for the poor and HIV/AIDS prevention provide a supportive policy environment to address these two issues. These laws are the Urban Development and Housing Act of 1992 for socialized housing and the Philippine AIDS Prevention and Control Act of 1998 for HIV/AIDS prevention. However, there is still a long way to go in addressing housing for PLWHA. Currently no urgency exists surrounding the issue, but with the alarming increase of cases in the Philippines, housing stability will become a big concern down the road. According to the Partnership of Philippine Support Services Agencies, “...the affected sectors should actively be involved with organizing communities to advocate for policy changes and developing government programs that address the problem or pilot possible interventions.”

Advocate testimony provided by Nicasio de Rosas of the Partnership of Philippine Support Service Agencies and TLF Share Collective. Photos provided by Nicasio de Rosas and the John J. Carrol Institute on Church and Social issues.

Sources:

National Economic and Development Authority, Medium-Term Philippine Development Plan, 2009.
More than just a Roof Over my Head:
Housing for People Living with HIV/AIDS around the World
Sub-Saharan Africa is the most rapidly urbanizing region; it is also the region with the highest slum prevalence and lowest access to safe water in the world. Approximately 70% of its urban residents are poor, while 60% of PLWHA are in Sub-Saharan Africa.
Cameroon

The HIV/AIDS Epidemic

In 2008, the HIV/AIDS prevalence in Cameroon was estimated at 5.1%, categorizing it as a generalized epidemic. The prevalence among women was higher (6.8%) than among men (4.1%) with prevalence highest in the age group between 20 and 39 years of age.

As in other parts of Sub-Saharan Africa, the HIV/AIDS pandemic has seen increasing feminization and infections among youth. In Yaoundé alone, 10.8% of women were infected at the end of 2009. Among 15 to 24 year-olds, prevalence was 4.3% in women, compared to 1.2% in men. In December, out of 228,812 pregnant women tested, 6.9% were found positive, of which only 9,092 benefited from antiretrovirals; 7,290 children exposed to the virus also benefited from medication. HIV/AIDS orphaned 122,000 children in 2005. In 2006, a national survey identified a lack of knowledge of HIV status and found that only 33% of women of reproductive age admit to having been tested and having received results.

Great disparities exist between urban and rural regions in Cameroon concerning HIV prevalence rates. In a 2004 national survey, the average prevalence in cities was 6.7%, compared with 4.8% in rural areas of Cameroon. This disparity can partly be attributed to the conditions in the urban settlements, underscoring the importance of addressing specific responses to the problem in the cities of Cameroon.

The Housing Crisis

Cameroon has an urban population estimated at 54% with an annual urban population growth of 5%. Yaoundé, like many other large African cities, has a population of 1.5 million and has been affected by rapid urbanization. People from rural regions come to the cities with high hopes of greater financial opportunities but are faced with a different reality when they arrive, struggling to find adequate housing and employment. Official statistics put the percentage of people living in Cameroon’s slums at 57.3%, though unofficial estimates put the figure anywhere from 70% to 80%. Access to water is limited to only 37.5% of the population, while electricity is much more available at 70%.

In this context of precarious housing conditions, opportunistic infection and HIV thrive. Poor access to water and sanitation increase opportunistic infection. Living in close quarters exposes children to early sexual activity and risky behavior.

People living in slums are faced with instability and are more vulnerable to forced evictions, expropriation, and dispossession. In Cameroon, forced eviction without resettlement or compensation is increasing. Very often little or no notice is given prior to eviction and demolition. In a survey conducted in 2007 in the community of Messa Carrière in Yaoundé, it was found that many people left for work in the morning only to come back and find their homes demolished and their possessions missing.

Women are made more vulnerable in these types of situations because they continue to experience discrimination in terms of housing, land tenure, access to land, inheritance, and access to information regarding their housing rights. HIV/AIDS renders women even more susceptible to housing and land insecurity. Lack of information and cultural practice around inheritance are especially problematic for women. Without land tenure, women’s housing
institutions are at risk. If a woman cultivates her husband’s or his family’s land or lives in a house belonging to her husband, she is at risk of being dispossessed of her housing in the event of her husband’s AIDS-related death.

**Institutional Response & Solutions**

Cameroon’s government has adopted a multi-sector approach to HIV that involves the main actors from the public, private, non-governmental, local, regional, and national sectors. Most of its HIV/AIDS program consists of basic activities that respond more specifically to the needs of the particular communities. The national government has prioritized urban areas, where most of Cameroon’s population is concentrated. They have geared awareness campaigns toward groups most at risk and areas where people are most vulnerable, including establishments that serve alcohol, hotels, internet cafés, stations, beauty shops, and, most of all, slums. The national response has committed to restructuring squatter areas and improving environmental and living conditions to promote healthier lives.

The main objectives of the plan are to reduce the rate of infection in the general population, increase universal access to treatment for PLWHA, and reduce the global impact of HIV/AIDS on orphans and vulnerable children (OVC). In order to achieve these objectives, six strategies have been identified. The first is to grant universal access to prevention in favor of target priority groups, including consultation and testing, prevention and taking care of PLWHA, condom use promotion, prevention of mother-to-child transmission, and the reinforcement of prevention strategies toward youth. The plan also aims to grant universal access to treatment and care to children and adults living with HIV, protection and support of OVC, the appropriation of the fight against HIV by main actors, promotion of research and epidemiologic surveillance, and finally to strengthen the coordination and management of partnerships, follow-up, and evaluation.

Coalition des ONG et OCB du Cameroun oeuvrant dans le domaine des établissements humains (CONGEH), a coalition of 30 NGOs and community-based organizations (CBOs) committed to improving housing and human settlement conditions, has adopted a Gender, AIDS and Habitat (GSH) mainstreaming approach in all of its program activities, such as the FOCAH loan fund and the Land Consultation Clinics. GSH recognizes that women are disproportionately affected by poverty and inadequate housing. These disparities are compounded by HIV/AIDS, which further decreases their economic power and in turn has a profound effect on living conditions and habitat. The Social Spaces are an example of an initiative that stimulates community-based initiative and discussion, in particular to improve women’s access to income-generating activities. The Social Spaces allow CONGEH to mobilize community leaders from within its network of organizations working on human settlements. It is a community space designed to reflect its community: its issues, resources, background, and local political context. Created in the grassroots, it has a legitimacy to respond to HIV issues and all other issues around women, youth, and housing.
World AIDS Day 2010: “Where we live can cause AIDS and opportunistic infection.”

Advocate testimony provided by Coalition des ONG et OCB du Cameroun oeuvrant dans le domaine des établissements humains (CONGEH). Photos provided by Priya Gopalen of Rooftops Canada / Abri International.

Sources:

Kenya

The HIV/AIDS Epidemic

Estimates of HIV prevalence in Kenya among the population aged 15 to 49 ranges from 6.3% to 7.4%, with female prevalence ranging from 8% to 8.4% and male prevalence ranging from 4.3% to 5.4%. HIV prevalence among young women aged 15 to 24 is four times higher (5.6%) than that of young men of the same age (1.4%). In total, 1.3 million to 1.6 million Kenyans are living with HIV. While total HIV prevalence has been declining over the past decade, new infections occur most frequently among men and women in stable partnerships, MSM, female sex workers, prisoners, and IDUs. HIV prevalence is greater in urban areas (8.4%) than rural areas (6.7%), but considering that 75% of the population resides in rural areas, the total number of HIV infections is higher in rural areas than in urban areas. Marriage status correlates with HIV risk; 44.4% of widows are HIV-positive, 14.3% of married people are HIV-positive, and 2.4% of those who have never been married are HIV-positive.

HIV/AIDS is the cause for half of Kenya’s population of 2.4 million orphans. Over three quarters of households with orphans have never received any kind of external support.

The Housing Crisis

While Kenya is an agriculture-based economy with only 40% of the population living in urban areas, Kenya is one of the most rapidly urbanizing nations in the region, with 50% of the population expected to live in urban areas by 2015.

Land in Kenya is divided into three categories: government land (which can be used by the government or leased to a private body); trust land held on behalf of communities or ethnic groups under customary law; and private land. This complex system has led to confusion and vulnerability to land-grabbing, both by the government and private entities. As rural to urban migration increases, many residents resort to squatting on government lands through the development of informal settlements. Considering that 60% of Kenya’s population lives on less than two dollars a day, these slums are often the only affordable housing option given the high cost of living, lack of access to the formal housing market, and land-grabbing. Between 60% and 80% of urban Kenyans live in slums and in large and small cities throughout the country, with little access to basic services, poor hygienic conditions, and insecure tenure characterized by persistent harassment by local authorities and a constant threat of demolition. For example, over 60% of Kenyan slum dwellers access their water from unsafe sources. Housing, water and sanitation services have been commodified and undermine the right to these basic services.

In a community mapping project carried out by the NGO Shelter Forum, the problems associated with poor housing conditions included the high price of construction materials; informal construction; lack of political will; gender exclusion and discrimination; lack of awareness of right to housing among the community; ignorance of appropriate building technologies, and; lack of awareness of savings for housing.

Under customary law and local custom, men are often the sole benefactors of property inheritance. Widows who have lost their husbands to HIV/AIDS-related deaths are often blamed for the illness and harassed by in-laws until they leave the marital home. Sometimes widows are subjected to wife inheritance and “ritual cleansing” practices (coerced sex with the widow), which only increase their vulnerability to HIV transmission. Stigma and discrimination...
often prevent women from accessing credit and other financial resources to secure land. This situation is exacerbated by undefined land rights, women’s lack of education and ignorance of their own rights, and the general culture of gender exclusion from positions of power and decision-making.

According to UN-Habitat, in Kenya “HIV/AIDS is heavily impacting the urban population – women in particular – and it constrains social and economic development. HIV/AIDS and gender issues need to be mainstreamed and integrated into all institutional responses; for too long HIV/AIDS has been perceived as requiring only a health sector response. A change of attitude in government and civil society needs to be encouraged through information, legislation and outreach activities to reduce stigma against people living with HIV and to raise awareness for prevention.”

**Institutional Response & Solutions**

HIV is included in Kenya’s development agenda “Vision 2030,” whose key objective is to transform the country “into a globally competitive and prosperous nation with a high quality of life by 2030.” The plan is divided into three areas of concern: economic, social, and political.

Kenya’s Orphan and Vulnerable Children (OVC) Policy was developed in 2008-2009 and calls for the scaling up of Kenya’s national cash transfer program to reach 75,000 households. By 2010, the program is expected to provide nutrition, education, and health services to over 100,000 households. PEPFAR’s OVC program provides a package of basic needs, including food and clothing, to over 500,000 orphans each year.

In 2000, the Kenyan government, in cooperation with UN-Habitat/World Bank Cities Alliances, initiated the Kenya Slum Upgrading Programme (KENSUP) with an aim to raise living standards for urban slum dwellers by addressing issues regarding housing and infrastructure, land tenure and employment, and the impact of HIV/AIDS. However, COHRE has criticized KENSUP’s efforts by pointing out that “as *habitability* and *physical accessibility* of housing units and access to services and infrastructure are improved through slum upgrading or redevelopment, tenure security* is undermined by the market competition for these improvements. The market undermines *affordability* and displaces slum dwellers to less convenient locations. Displacement means that both *affordability* and *tenure security* have been undermined and access to convenient *location* is lost.”

The cost of improving livelihoods for the 5.4 million Kenyans living in slums is estimated at $12 billion USD. Urban annual housing demand for all social classes is estimated at 150,000 units, while annual production only provides 40,000 to 50,000 units. Of these new units, only 20% are targeted for low-income households. The cost of meeting the annual housing deficit of 100,000 units is $2 billion USD. An estimated 300,000 housing units require improvements annually at an average cost of $1,000 USD each. This will require over $307 million USD from the rural housing improvement program.
Structural changes in land policy and urban management may reduce slum formation. Pro-poor land management and taxation must be implemented in order to encourage economic and social development within slums. According to Shelter Forum, the community has to improve its housing conditions by collaborating with stakeholders to initiate low-cost building technologies using locally available materials from within the community. Women’s rights, including property and inheritance rights, must be protected via reformed legislation.

Image: Women employing low-cost housing technology using stabilized soil blocks in Bungoma, Kenya

Advocate testimony and photos provided by Dorice Yete-Vete Bwoga of Shelter Forum.

Sources:
Huchzermeyer, Marie (COHRE), Slum upgrading initiatives in Kenya within the basic services and wider housing market: A Housing Rights Concern, 2006.
UN-Habitat, Kenya Slum Upgrading Programme (KENSUP), 2010.
UN-Habitat, Kenya Urban Sector Profile, 2005.
Nigeria

The HIV/AIDS Epidemic

Twenty-three years after the first case of HIV appeared in Nigeria, HIV still poses health and development challenges to the country. Nigeria is ranked second in the number of people living with HIV/AIDS (after South Africa), reflecting about 9% of the global HIV burden. HIV prevalence in Nigeria is estimated at 3.6%, with 4.6% prevalence among pregnant women. Based on the 2008 HIV prevalence rate, the National Agency for the Control of AIDS (NACA) estimates that about 2.95 million people are living with HIV in Nigeria. Of this figure, 833,000 individuals require ARVs. As of March 2009, 267,710 adults and 14,857 children living with HIV were on ARVs. Even though Nigeria’s epidemic is generalized, there is a significant disparity of HIV prevalence by geographical location, sex, age and sub-population groups. Prevalence is slightly higher in urban areas (3.8%) than in rural areas (3.5%). HIV prevalence is highest among individuals between 25 and 29 years of age (5.6%) and more women are living with HIV than men (1.72 million females: 1.23 million males). HIV prevalence among sex workers, MSM, and IDUs is higher than the national average of 4.6%. Heterosexual sex is the primary mode of transmission.

Nigeria’s multi-sectoral response to HIV, led by NACA, has recorded remarkable achievements by lowering national HIV prevalence from 5.8% in 2001 to 5% in 2003 and 4.4% in 2005. However, this decline was followed by a recent rise to 4.6% in 2008. According to NACA, the drivers of the HIV epidemic in Nigeria include low risk perception, multiple concurrent partners, informal transactional and inter-generational sex, lack of effective services for sexually transmitted infections, gender inequalities, and inadequate health services.

In its country progress report to UNGASS in March 2010, NACA stated that the spread of HIV “promotes poverty.”

The Housing Crisis

Nigeria is the largest and most urbanized country in sub-Saharan Africa. Approximately 45% of Nigeria’s population lives in urban areas; the slum to urban population ratio is 79%. Rapid urbanization is putting stress on the housing supply, which has resulted in overcrowding. In addition, home prices and rents outpace inflation. Rent in major cities represents approximately 60% of an average income. Estimates of the total housing deficit in Nigeria range from 10 to 17 million units. As a result, informal settlement communities have developed across the country.

The Center on Housing Rights and Evictions (COHRE) has named the Government of Nigeria one of the worst violators of housing rights in the world. In 2008, COHRE reported that over 2 million Nigerians had been forcibly evicted from their homes since 2000; 800,000 of those had been evicted from their homes in informal settlements in Abuja by the Nigerian government from 2003 to 2007 as part of the Abuja Master Plan to move the Federal Capital from Lagos to Nigeria.

The Association of Positive Youth Living with HIV/AIDS in Nigeria estimates that one out of every three PLWHA in Nigeria resides in slums characterized with poverty and continuous ill health. People living with HIV/AIDS in Nigeria face challenges of poor health and quality of life due to overcrowded conditions, poor public services and infrastructure because of their substandard housing. These poor conditions result in increased stigma and discrimination.
Institutional Response & Solutions

NACA’s HIV/AIDS Policy was revised in 2009 to address emerging issues, including the expansion of orphans and vulnerable children; the stigmatization of PLHWA and human rights violations; and issues associated with increased access to treatment and care. NACA also recognizes that addressing gender inequality is crucial in the control of the epidemic. However, the extreme housing shortage and health disparities associated with living in slums are not recognized as a factor of the HIV/AIDS epidemic or the institutional response.

According to advocates, “making housing work in Nigeria” has become a functional HIV/AIDS advocacy campaign issue. So far, informal and formal meetings have been held with different HIV/AIDS stakeholders regarding housing in Nigeria, and NACA has shown interest in this course of action. There have also been advocacy meetings and sensitizations aimed at individuals and organizations working in the field of health to consider housing as a crucial prevention strategy in the country. The Association of Positive Youth Living with HIV/AIDS in Nigeria (APYIN) organized an advocacy/skills-building session on housing during the 5th HIV/AIDS National Conference in May 2010. APYIN hopes to form a concerned body known as HIV/Housing Group. This group will work hand in hand with the government and other international bodies to realize the goal of housing in the country.

Advocate testimony and photos provided by Daniel Obiomachukwu Peter Onyeigwe of the Association of Positive Youth Living with HIV/AIDS in Nigeria.

Sources:

Dar es Salaam, United Republic of Tanzania

The HIV/AIDS Epidemic

HIV prevalence in Dar es Salaam, the major economic city and port for Tanzania, is around 9%, compared to a national prevalence that has stabilized at around 6%. Urban HIV prevalence is almost twice as high as rural HIV presence across the country, though the epidemic is expected to rise in poorer rural areas. HIV prevalence is higher among the wealthy than among the poor. Dar es Salaam is the region with the second highest HIV incidence, following Iringa.

The Housing Crisis

Dar es Salaam has a population of four million people, making it Tanzania’s largest city. Tanzania is urbanizing at a rate of 6% per year, and the large population growth of Dar es Salaam, in part due to the arrival of 100,000 migrants per year, has not been accompanied by effective urban planning, resulting in rapid urban sprawl and horizontal expansion. Approximately 70% of the city’s residents live in informal settlements, many of which lack essential services such as electricity, water and sanitation, solid waste management, and health and education facilities. According to data from the Ministry of Lands, Housing and Human Settlements, 80% of Dar es Salaam’s housing units are in unplanned settlements. Most slum homeowners lack official titles to their homes, and women own 11% of the homes. The majority of slum dwellers work in the informal sector, if they work at all. Estimates indicate that 50% of slum dwellers in Dar es Salaam live on an average income of one dollar a day.

Institutional Response & Solutions

The main objective of Dar es Salaam’s Community Infrastructure Upgrading Program (CIUP) is to “improve the living and economic conditions of the communities in Dar es Salaam through the provision of basic infrastructures and services. In so doing, it will also alleviate poverty by increasing employment and income generation opportunities.” However, CIUP had been executed in just 31 of the city’s 71 informal settlements by July 2008, representing only 20% of the city’s unplanned areas.

All national policies in Tanzania are guided by the National Strategy for Growth and Reduction of Poverty, whose aim is to promote “equitable, broad-based and sustainable economic growth and reduction of poverty and vulnerability.” Tanzania’s national health policy prioritizes the most vulnerable and recognizes health as an essential resource for poverty reduction; however, it does not identify who the most vulnerable groups are. The national AIDS policy “recognizes the vicious circle between HIV and AIDS and poverty, and therefore stresses interventions for control of the epidemic to be simultaneously related to poverty alleviation initiatives.”
Informal business in the slums of Dar es Salaam

Advocate testimony and photos provided by Andreas Nshala of HIV/AIDS Anonymous International.

Sources:

Kaihuzi, Magdalena (HIVAI), Home Property Ownership Assessment in Low-Income Areas of Dar es Salaam City with more Focus on Property Ownership by Women: Survey in Ilala, Kinondoni and Temeke Municipalities, 2008.
Kampala, Uganda

The HIV/AIDS Epidemic

Approximately 940,000 Ugandans are living with HIV/AIDS. HIV prevalence is 10% in urban areas and 6% in rural areas. The HIV prevalence in Kampala is 8.5%. In Kampala, as in all regions, women have a higher HIV prevalence than men (7.5% compared to 5% for men nationally). Higher HIV prevalence is associated with higher education and wealth levels. The epidemic is now generalized in the general population but particularly in pockets of fishing communities, long distance truck drivers, people 35 to 49 years of age, sex workers, mobile and married populations.

The Housing Crisis

Uganda’s population is estimated at 30 million people, 14% of which live in urban areas. Approximately 93% of the urban population lives in slums. Slum dwellers face challenges such as security of tenure, access to affordable and quality education, medical care, energy, and water and sanitation management, along with a high incidence of HIV/AIDS.

Kampala, with a population of over 1.4 million, is surrounded by numerous slum dwellings that constitute the majority of the population’s housing. Shelter and Settlements Alternatives, a non-governmental organization working in five slum communities in Kampala, identified the following problems associated with slum dwellings: quality of affordable housing, evictions by landlords, issues of property inheritance, stigma and lack of health care. Most people in slum communities cannot afford adequate housing because their economic providers have died of AIDS-related causes. Some residents have inadequate incomes, and others are widows who lost their homes following the death of their husbands. It is not culturally acceptable for women to inherit property; widows’ only alternative is to find cheaper housing in slums. Other times, those suffering from HIV/AIDS are evicted, either by their own fathers- and brothers-in law, or by landlords due to complaints of other tenants and fear that future tenants will refuse to live in the former home of PLWHA.

HIV-positive slum residents face substantial stigma and discrimination, especially those who sell food or perishables. “The community looks at them as dirty and cannot support them. They avoid buying anything from them,” explained a community member in Kisenyi, a Kampala slum. This stigma only increases the economic crisis for positive residents, who are left without enough money to secure their housing, medical bills, school fees and food. Health workers also face difficulties carrying out home visits for slum dwellers, especially during the rainy season when accessibility is very difficult due to flooding, which increases infections and limits patient outreach.

HIV-positive slum residents are more vulnerable to issues of housing instability because they are often unable to work due to their medical condition, and thus cannot save enough money to move into better shelter. Most positive residents save the little money they have for medical treatment and thus the only dwellings affordable are slum dwellings. Some HIV-positive residents fear that they may leave their families in worse housing conditions upon their death, which leads them to remain in the slums in order to save money to leave for their families.

Most HIV-positive slum dwellers, like all slum tenants, lack collateral security. They cannot borrow money from the bank or individual money lenders, and so their hopes of getting better
housing are limited. Some cannot join saving cooperatives because they do not have the startup capital. Lack of housing finance and security invokes anxiety, sometimes to the point of suicide: “We have had cases where people have killed themselves because of stress and worrying due to evictions by landlords,” explained another Kisenyi resident. Some of the HIV-positive slum residents lost their parents before they were educated and thus cannot obtain well-paying jobs that would allow them to move to better housing conditions.

**Institutional Response & Solutions**

Governmental programs and strategies to reduce the impact of HIV/AIDS have overlooked violations of women’s housing, land and property rights. Various non-governmental organizations are working in the Kampala slums to fix the problems of housing insecurity. Uganda Cooperative Alliance and Slum Dwellers International trains residents to join cooperatives and save for better housing. Uganda Cooperative Saving, Community Initiative for Development International and Credit Union and Act Together train people in information sharing and awareness-raising. The Red Cross has helped in securing alternative settlements, improved diets and access to medication. Concern Worldwide has improved drainage systems along with training communities on improved income-generating activities.

Ugandan laws protecting inheritance and property ownership are rarely enforceable due to corruption. Various governmental institutions, such as the Ministry of Labor and Gender, the local Welfare and Probation Officers, the police Family and Children Unit, and the Administrator General’s Office are all centralized and inaccessible to those in need. Several organizations and legal aid projects are in place to fight violations of property and inheritance rights, such as the Human Rights Commission, the Federation of Women Lawyers, COHRE, the Platform for Labor Action, and others, but these are often prohibited by the costs associated with outreach and follow-up.

According to Shelter and Settlements Alternatives and the Global Coalition of Women Against AIDS in Uganda, the solutions for housing HIV-positive people are multifaceted. Key housing issues that are pertinent to positive slum residents can then be brought to light and advocated for, such as mainstreaming HIV and gender in housing movements, with special consideration on how housing impacts HIV/AIDS and gender and how HIV/AIDS and gender impact housing. Clear strategies and policies both for organizations and government can then follow from these discoveries. Capacity building – training community paralegals to teach positive residents their rights, including anti-discrimination and stigma training for the community, its leaders, and local officials, provide access to emergency support, and improve their economic livelihood skills to encourage financial sustainability and personal empowerment – will tackle many of the issues associated with housing vulnerability for HIV-positive people.

“My parents died when I was 12 and they left me with their property. After sometime, I was tested HIV positive; I started becoming weak and could not work to earn a living. Lucky enough, I had houses to rent out and the money I got kept me going. One day a relative who stays overseas came in to sell my property after knowing that I was HIV positive. I had no one to defend me and part of my property was sold. Since the houses I was renting were also sold, I was left with no alternative to earn a living. I was left with a small part of land with one poor house where I stay now. Today, I depend on well-wishers since I am already bedridden and cannot go out to make money. All these situations have weakened me to an extent that even the medicine I take cannot improve my health. The house I live is in a bad condition and this does not give me piece of mind at all. I do not have money to improve on my house since every coin...
I get now is spent on drugs. For now, I do not know what the future holds for me. I depend on friends and do not even think I will have a better house."

Advocate testimony and photos provided by Eunice Kyomugisha of Shelter and Settlements Alternatives and by Flavia Kyomukama of the Global Coalition of Women against AIDS in Uganda.

Sources:

Zambia

The HIV/AIDS Epidemic

HIV prevalence in Zambia is 14.3%. Vulnerable populations include female sex workers, MSM, prisoners, and STI and TB patients, though HIV prevalence among vulnerable groups has not been systematically monitored. However, HIV incidence in adults has stabilized at 1.6% (2% in women, 1.2% in men). Urban adult HIV prevalence at 19.7% is almost twice that of the rural areas, 10.3%, and adults with higher education are more at risk of HIV infection compared to those with little or no education. The HIV prevalence in prisons, 27%, is almost double that of the general adult population; condoms are banned from prisons.

In its 2010 Country Report to UNGASS, Zambia’s National AIDS Council (NAC) recognized that “for each affected household and person, HIV brings economic pressures and disadvantages that tend to increase poverty.” Mobile populations and prisoners have been targeted for prevention programs along with other vulnerable groups. Documented barriers to accessing antiretroviral treatment and medical care include the costs of transportation, food and accommodation, as well as the replacement cost of work and care-giving.

The Housing Crisis

Zambia is one of the most urbanized countries of sub-Saharan Africa, second only to South Africa, with 40% of the population living in urban areas. Approximately 74% of the urban population lives in slum conditions, while on the human development index Zambia ranks 164th among 182 countries, or in the lowest 10%. About 36% of the population is economically inactive; up to 87% of the population live on less than two dollars a day. The peri-urban slums are characterized by overcrowding, inadequate water supply, poor sanitation and drainage, uncollected solid waste, and inadequate security of tenure.

The majority of Zambian households are led by men, and so women depend on men for their housing security and economic livelihood. Women have little legal power to protect their assets and the security of their home when they lose their husbands to HIV/AIDS. Many widows lose their property to their in-laws upon the death of their husbands. Widows are often blamed for their husbands’ death, and sometimes a widow is forced into sexual relations with her brother-in-law as “sexual cleansing.” Customary inheritance laws dictate that property and assets of the deceased be left to parents and siblings, leaving widows at a disadvantage. Statutory law dictates that the assets of a man who dies without a will are divided 50% to the wife and children, 20% to his parents, 20% to his siblings and the remaining 10% to other dependants. However, this law is largely unknown, and often not respected given its contradiction with customary inheritance law.

According to a community survey carried out by the Treatment Advocacy and Literacy in Chazanga, where HIV transmission is concentrated among the poor, the main problem associated with housing in the community includes quality of affordable housing and issues with property/inheritance rights and displaced populations. HIV-positive residents in Chazanga are more vulnerable to issues of housing instability because of lack of income; many have lost employment prematurely due to poor health, while others must prioritize their savings for medical expenses.
Institutional Response & Solutions

The government of Zambia does not have a clear policy for how to deal with informal or unplanned settlements. Various attempts have been made to formalize the settlements, but progress has been slow and hampered by financial and human resource constraints at both the national and local government levels. Numerous government requirements hinder the provision of basic infrastructure and services and the granting of secure tenure to existing informal settlement occupiers.

Zambia still does not have a law protecting PLWHA from discrimination. One of the goals in the country’s Strategic Framework is to provide social support for “those made vulnerable by the HIV and AIDS epidemic.” Strategies to achieve this goal include: (1) Protect and provide support for OVC; (2) Provide social protection for people made vulnerable by HIV/AIDS; and (3) Promote programs of food security and income/livelihood generation for PLWHA and their care-givers and families. Approximately 15.7% of households with OVC receive external support in the form of medical care and supplies, school-related assistance, counseling, or other social support, including clothing, food, housing, and financial support.

The Bwafwano Care Project provides housing and support for elderly populations and houses with OVC. However, according to advocates the major obstacles to providing adequate shelter for PLWHA are lack of adequate resources and the stigma and discrimination associated with the pandemic. The Treatment Advocacy and Literary Campaign is calling on the Global Fund to allocate funds for housing for PLWHA in their disbursement to Zambia.

Advocate testimony provided by Harrison Mwima of the Treatment Advocacy & Literacy Campaign.

Sources:

Developed Countries

Australia, the United Kingdom, and the United States, while boasting higher human development indexes and fewer informal settlements, still suffer from high economic inequalities and a generalized lack of affordable housing. The consequences of global migration patterns and the legacies of colonialism, racism and homophobia on PLWHA often place the most burdens on marginalized immigrant communities, MSM and people of color in terms of accessing affordable housing, secure employment, and adequate prevention and treatment services.
**Sydney, Australia**

**The HIV/AIDS Epidemic**

Sydney’s HIV/AIDS epidemic is the largest and most concentrated in Australia. 2009 figures indicate a prevalence of 15,000 for the state of New South Wales. Incidence is declining in MSM and IDUs and increasing in women and aboriginal communities.

There is little difference in overall HIV/AIDS incidence rates between indigenous and non-indigenous people, but the method of HIV transmission differs significantly between these populations. Sexual contact between men accounted for 54% of HIV transmission in aboriginal communities and 67% of exposure in non-aboriginal communities. Heterosexual contact accounted for 23% of transmission in both the aboriginal and non-aboriginal communities. Injection drug use is higher among the aboriginal community (22%) than the non-aboriginal community (3%), while aboriginal women have a higher proportion of HIV infection (26.9%) than non-aboriginal women (11.6%).

**The Housing Crisis**

Estimates indicate that 1-3% of PLWHA in Sydney are either homeless or unstably housed. The main problem is the shrinking housing supply for PLWHA. Because housing need is greater than the supply, people with the most severe disabilities qualify for housing, which does not include PLWHA. There has been a bureaucratic shift since the late 1990s to reduce funding resources that support PLWHA. As PLWHA in Sydney, as a whole, are living longer and better, they are being forced to provide more for themselves, as evidenced in historical governmental funding streams. However, since funding has never been adequate, the reduction in funding places even more housing burden on PLWHA. Of course, stigma is always underlying.

PLWHA are more vulnerable to housing instability because once HIV is combined with another identity such as gender, cultural and linguistic difference, mental health issues, transactional sex, IDU, etc., there is a disproportionately large devastating effect. These social determinants of HIV health often lead to housing insecurity and need. For example, aboriginal PLWHA often have issues with unemployment, drug abuse and illiteracy, creating specific needs.

**Institutional Response & Solutions**

No institutions exist solely to address housing vulnerability for PLWHA. However, most of the HIV organizations are responsible for responding to the issue. New South Wales’ Department of Health runs several housing facilities for PLWHA, while the main HIV-related NGO provides housing support and a welfare-style NGO provides social work assistance in the area.

According to the People Living with HIV Project, “there needs to be a shift toward increased funding for housing PLWHA. Decreasing the stigma associated with HIV/AIDS would improve the overall situation.”

*Advocate testimony provided by Barry Freedman of the People Living with HIV Project.*

**Sources:**


UN-Habitat, Australia Statistical Overview, 2010.
Canada

The HIV/AIDS Epidemic

The number of people living with HIV is continuing to increase in Canada, from approximately 57,000 people living with HIV in 2005 to approximately 65,000 people living with HIV in 2008. Although some of this increase can be attributed to the fact that people with HIV are living longer thanks to modern antiretroviral therapy, the number of new HIV infections is not decreasing. In 2008 alone, there were an estimated 2,300 to 4,300 new HIV infections. An estimated 26% of people living with HIV are unaware of their HIV status.

Although men who have sex with men (MSM) have the highest rate of new HIV infections in Canada, women, persons from endemic countries and Aboriginal persons are at high-risk of contracting HIV. Aboriginal persons and persons from endemic countries are currently over-represented in the HIV epidemic in Canada, with incidence rates of 12.5% and 16%, respectively in 2008.

The number of new HIV infections from injection drug use (IDU) increased to 17% in 2008. Among Aboriginal people, IDU is the predominant HIV exposure category, representing 66% of new HIV infections in 2008. IDU is also an increasing exposure category among women, increasing from 27% of new infections among women in 2005 to 29% in 2008.

The Housing Crisis

Over 13% of urban Canadian households were deemed to be in core housing need in 2005 (based on the definition of acceptable housing as that which is in adequate condition, of suitable size, and affordable). This problem is even more acute in the Aboriginal population, where 20.4% of Aboriginal households were in core need in 2006. Affordability, adequacy and suitability are all key issues of concern. The housing problem among Aboriginal people has led to increased susceptibility to various health concerns, such as tuberculosis and influenza.

In Ontario, almost half of people living with HIV or AIDS have problems with housing, as determined by the Positive Spaces Healthy Places (PSHP) research study. This study found that housing instability puts PHAs at risk for concerns related to safety, security and social exclusion. These issues are exacerbated by key social determinants of health that negatively impact the mental health of people living with HIV. These issues are more acutely experienced by people living with HIV of Aboriginal, African and Caribbean descent as a result of racism and the long term impacts of colonization. According to PSHP, women are also particularly vulnerable to housing instability. In the PSHP study, women living with HIV had a 15% lower monthly income then men, their housing costs were 20% higher than men, they were 40% less likely to move than men and they are three times more likely to be unstably housed than men.

HIV and AIDS and housing instability often go hand-in-hand. Housing discrimination within the current system is a major area of concern for people living with HIV. There is a growing consensus among AIDS service organizations, researchers, front-line workers, and policy-makers that housing is a key factor affecting the health and well-being of people living with HIV. Affordable, safe, supported, and stable housing can help mitigate the effects of poverty, stigma, and illness.
Institutional Response & Solutions

Funding for supportive and rent-geared-to-income housing is a provincial jurisdiction and varies from province to province. At the provincial level, AIDS service organizations are at various stages of working with provincial housing ministries to increase the housing options available to people living with HIV. An Ontario-focused housing and health symposium identified key research priority areas. The Prairie Regional Health and Housing Symposium called for on-going research, engagement of policy and decision-makers, and increasing cooperation across sectors. Lead by COCQ-SIDA and the Canadian AIDS Society, a research initiative bringing together universities, community researchers, housing providers and AIDS service organizations is being planned in Quebec.

At the Federal level, several policy initiatives make the connection between housing and HIV and call for action. The Federal Initiative to Address HIV/AIDS in Canada calls for federal agencies and departments involved with housing to be more engaged in the national HIV/AIDS responses. Leading Together: Canada Takes Action on HIV/AIDS (2010) lists adequate and affordable housing as one of the complex needs of people living with HIV. It calls for greater government investment in this area, as well as increased partnerships within the health care system and beyond, including those individuals, organizations and agencies who are involved in housing. The Canadian Aboriginal AIDS Network is developing a five year national strategy on HIV/AIDS and housing for Aboriginal communities. Bring Me Home: The Canadian AIDS Society’s Position on Housing and HIV/AIDS calls for the development of a national strategy for housing and HIV/AIDS. It has committed to reviewing national and international housing strategies to compile effective policy recommendations for a Canadian initiative.

Advocate testimony provided by Melanie Mayoh of the Ontario HIV Treatment Network.

Sources:

Bekele T. et al, Direct and indirect effects of social support on health-related quality of life among persons living with HIV/AIDS: Results from the Positive Spaces Healthy Places Study (submitted), AIDS Care, 2010.


Ticknor, Jann and Belle-Isle, Lynne, HIV and Housing: Toward a National Housing Strategy, Canadian AIDS Society, 2010.
**United Kingdom**

**The HIV/AIDS Epidemic**

Approximately 83,000 people are living with HIV/AIDS in the United Kingdom, which is equivalent to 0.2% prevalence. About 27% of those living with HIV are unaware of their status. Around 50% of those diagnosed with HIV are heterosexual, while 42% are MSM and 2.4% are IDUs. MSM and African heterosexuals represent the groups most at risk for HIV infection and account for 80% of those receiving treatment in the UK. The majority of HIV-positive Africans living in the UK acquired their infection in Africa (87%). In a study among Ethiopian and Eritrean communities in London, many respondents believed that they had left the problem of HIV/AIDS back in Africa, in part because there was no outreach or messaging regarding HIV prevention and the consequence of contracting HIV that reached immigrant communities.

**The Housing Crisis**

International migration to the UK has increased substantially since the 1990s. During this time, social (affordable) housing stock has considerably decreased. About 11% of new migrants have been allocated social housing, compared with 17% of residents born in the UK and 18% of residents born outside the UK, even though immigrants’ average income is the lowest of these three groups. Immigrants are eligible for social housing once their application to remain in the UK as refugees has been accepted. The Ministry of Home Affairs usually take three to five years to make a decision in such cases. In the majority of cases, most immigrants are refused refugee status and asked to leave the UK. Most people living with HIV do not leave the country, but instead live “underground” with friends or family members. In some cases, when immigrants are waiting for their decision on their application, the Ministry of Home Affairs accommodates them in hotels. However, in most cases, immigrants living with HIV live in sub-standard accommodation and some of been infected with TB and other co-infection diseases. In a study comparing social and economic hardship of PLWHAs by background, African immigrants faced more challenges related to housing, employment and income than any other group.

**Institutional Response & Solutions**

The UK government has improved legislation to combat stigma and discrimination, specifically through the Disability Discrimination Act, the Gender Recognition Act and Civil Partnership Act, and the Equality Bill. However, these laws do not specifically address the immigrant population. Greater connection between AIDS service organizations and immigrant communities is required for HIV prevention, treatment and care to reach immigrant populations.

The Addington Afro-Ethnic Health Promotion Group (AAEGRO) provides support and advice to immigrants living with HIV in South London. They have a hotel where some clients are accommodated temporarily while applying for local authority housing, but housing need far outstrips supply.

*Advocate testimony provided by Elias Phiri of the Addington Afro-Ethnic Health Promotion Group.*

**Sources:**


Rutter, Jill and Maria Latorre (ippr), Social Housing Allocation and Immigrant Communities, 2009.


WHO, UNAIDS & UNICEF, Epidemiological Fact Sheet on HIV and AIDS: Core Data on Epidemiology and Response, United Kingdom, 2008.
United States

The HIV/AIDS Epidemic

Approximately 1.1 million Americans are living with HIV/AIDS, with over 56,000 new HIV diagnoses each year. MSM account for 53% of PLWHAs, while individuals infected through high-risk heterosexual contact and injection drug use account for 31% and 12% of PLWHAs, respectively. Three men are infected for every woman infected, and AIDS is the leading cause of death for black women ages 25 to 34. Black people account for more HIV infections, AIDS cases, and HIV/AIDS related deaths than any other racial or ethnic group in the United States. While Latinos only account for 15% of the population, they represent 17% of all new HIV infections.

The Housing Crisis

AIDS housing experts estimate that about half of PLWHAs in the United States – over 500,000 households – will need some form of housing assistance during the course of their illness. Housing is the greatest unmet service need for PLWHAs. Approximately 72% of PLWHAs have annual incomes below $30,000, while the National Low Income Housing Coalition’s “Out of Reach 2010” reports that “assuming full-time, year-round employment, the 2010 national Housing Wage for a two-bedroom rental unit at the national average fair market rent of $959 is $18.44. This means that a household must earn the equivalent of $38,360 in annual income to afford a modest rental home.” Therefore housing is simply not affordable for the vast majority of PLWHAs in the United States.

Increasing evidence directs attention to the role of housing – or lack of housing – for the continuing HIV epidemic and associated health disparities in the United States. Housing status has been identified as a key structural factor affecting access to treatment and health behaviors among PLWHAs, and research shows that receipt of housing assistance is associated over time with reduced HIV risk behaviors and improved health care outcomes. Housing is increasingly identified as strategic point of intervention to address HIV/AIDS and overlapping vulnerabilities associated with race and gender, extreme poverty, mental illness, chronic drug use, incarceration, and histories of trauma and violence.

Homelessness and unstable housing are strongly associated with greater HIV risk, inadequate health care, poor health outcomes and early death. Recent findings contribute significantly to the body of research showing strong and consistent correlations between housing status and health care access and outcomes among PLWHAs. Investigators from two major multi-year studies – the CDC’s and HUD’s Housing and Health (H&H) Study and the Chicago Housing for Health Partnership (CHHP) Study – have released preliminary findings that link housing assistance to improved health outcomes for homeless and unstably housed PLWHAs and other chronic health conditions, and show that public investment in housing not only improves health outcomes but actually saves taxpayer money. Findings show that homelessness and unstable housing are associated with increased rates of HIV sex and drug risk behaviors; that unstable housing increases HIV risk behaviors even among those at highest HIV risk; and that the association between lack of stable housing and greater HIV risk behaviors remains even among persons who have received risk reduction services. Significantly, persons with stable housing are less likely to engage in risky behaviors, and more likely to reduce risk behaviors, than their counterparts who are homeless/unstably housed.
Institutional Response & Solutions

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 (earning 80% of area median incomes). Three types of grants are made under the HOPWA program:

- formula grants are made using a statutorily-mandated formula to allocate approximately 90% of HOPWA funds to eligible cities and states
- competitive funds are awarded on the basis of a national competition
- technical assistance funds are also awarded through a national competition

Approximately 94% of households served by the HOPWA program achieve permanent housing stability. However, at current funding levels, HOPWA serves only about 58,000 households per year, reaching only about 30% of HOPWA-eligible households with housing needs.

On December 17, 2009, the White House Office of National AIDS Policy (ONAP) convened a consultation on the role of housing in HIV prevention and health care. In opening remarks, ONAP Director Jeff Crowley noted that housing had been a central theme of the fourteen community meetings held across the United States to gather input on the National AIDS Strategy, with housing repeatedly cited as a critical unmet need. He charged those present to provide concrete guidance on how housing should be reflected in the NHAS to order to advance its three primary goals: reducing HIV incidence; increasing access to care and optimizing health outcomes; and reducing HIV-related health disparities. Participants produced findings and recommendations that were submitted to ONAP.

“PLWHA need to be in a daily routine that includes nutrition, medication, rest and low levels of stress besides others. If these routines are not met because of housing, there is a big probability of failing treatment which may incur in developing resistance to meds, higher viral loads with increased rates of infection. Housing is a primary need for anyone, but for PLWHA it also means a public health policy concern.”

Advocate testimony provided by Marcelo Maia of the Gay Men’s Health Crisis. Photos provided by Kathie Hiers of AIDS Alabama and Larry Bryant of Housing Works, Inc.

Sources:
National Low Income Housing Coalition, Out of Reach 2010, 2010.
WHO, UNAIDS & UNICEF, Epidemiological Fact Sheet on HIV and AIDS: Core Data on Epidemiology and Response, United Kingdom, 2008.
Annexes
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

Whereas adequate and secure housing has long been recognized as a basic human right,

Whereas growing empirical evidence shows that the socioeconomic circumstances of individuals and groups are equally or even more important to health status than medical care and personal health behaviors,

Whereas in the case of HIV/AIDS, the link between poverty and disparities in HIV risk and health outcomes is well established, and new research findings demonstrate the direct relationship between inadequate housing and greater risk of HIV infection, poor health outcomes and early death,

Whereas poor living conditions, including overcrowding and in extreme cases, homelessness, undermine safety, privacy and efforts to promote self-respect, human dignity and the attendant responsible sexual behavior,

Whereas the lack of stable housing directly impacts the ability of people living in poverty to reduce HIV risk behaviors and homeless and unstably housed persons are two to six times more likely to use hard drugs, share needles or exchange sex than similar persons with stable housing,

Whereas, in spite of the evidence indicating that adequate housing has a direct positive effect on HIV prevention, treatment and health outcomes, the lack of adequate housing resources has been largely ignored in conferences and policy discussions at the international level, and

Whereas the United Nations, in both its 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS, embraced the goal of universal access to comprehensive prevention programs, treatment, care and support by 2010.

Therefore, we hereby demand that policy makers address the lack of adequate housing as a barrier to effective HIV prevention, treatment, and care; and we further demand that all governments fund and develop housing as a response to the AIDS pandemic.
International AIDS Housing Roundtable

Founding Partners:
National AIDS Housing Coalition (USA)
Ontario HIV Treatment Network (Canada)
San Francisco AIDS Foundation (USA)
Housing Works, Inc. (USA)

Allied Organizations:
Addington Afro-Ethnic Health Promotion Group (UK)
AIDS Housing Alliance (USA)
AIDS Niagara (Canada)
Alma Viva (Chile)
Ambassadors of Change (Kenya)
AZUR Development/ Réseau Sida Afrique (DRC)
Association of Positive Youth Living with HIV/AIDS (Nigeria)
Bailey House, Inc. (USA)
British Columbia Center for Disease Control (Canada)
C2EA Youth Caucus (USA)
Campus Health & Rights Initiative, Obafemi Awolowo University (Nigeria)
Caribbean Harm Reduction Coalition (St. Lucia)
Center on Housing Rights and Evictions (Ghana)
China Red Ribbon Volunteer League (China)
Citiwide Harm Reduction (USA)
Comunidad Internacional Siloé (Costa Rica)
CONERELA (DRC)
CONGEH (Cameroon)
Czech AIDS Help Society (Czech Republic)
Delaware HIV Consortium (USA)
EMPOWER (India)
Family Guidance Association (Ethiopia)
Fife House (Canada)
Global Coalition of Women Against AIDS (Uganda)
Global Network of People Living with HIV/AIDS (Global)
Global Youth Coalition on HIV/AIDS (Honduras)
International Community of Women with HIV/AIDS (Panama)
LifeLine Plus Foundation (Nigeria)
Metropolitan Washington Public Health Association (USA)
National Cooperative Housing Union (Kenya)
National Youth Network on HIV/AIDS (Nigeria)
Network of People Living with HIV/AIDS – Mar de Plata (Argentina)
New York City AIDS Housing Network (USA)
Odessa Regional Charity Foundation "Future Without AIDS" (Ukraine)
People Living with HIV Project (Australia)
Philippine Support Service Agency (Philippines)
Positive Women’s Network (USA)
Pro-Hope International (Gambia)
Red Habitat (Bolivia)
Red Latinoamericana de Personas con VIH (Latin America)
Rooftops Canada / Abri International (Canada)
Shelter and Settlement Alternatives (Uganda)
Shelter Forum (Kenya)
Swedish Co-Operative Centre (Sweden)
The AIDS Support Organisation (TASO)
Soroti Centre (Uganda)
Treatment Advocacy and Literacy Campaign (Zambia)
United Foster Parents Plan (Uganda)
Youths for Peace Building and Development in Africa (Nigeria)
Zambia National Antiretroviral Support Programme (Zambia)