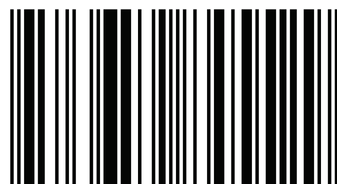
HIV/ AIDS: Household Coping Mechanisms of the Poor in Kenyan Slums

This book on HIV/AIDS is a new manifestation of the untold silence and the emerging coping mechanisms of the Poor in informal settlements in Kenya. It reflects what happens in slums elsewhere in the World today, especially now that there is diminishing resources for the fight of the scourge and low participation of stakeholders in less developed Countries in the African Continent. It is a piece each health institution may want to look at for their appraisal.

Dr. Ndolo has been a University Lecturer for over 20 years. An author, researcher and consultant on poverty, gender, Project planning and management, Needs assessment, project Monitoring and Evaluation and Environmental Impact Assessment and Audit and many other issues. His research interests are in Governance, Child Rights and Health.



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M. Ndolo

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HIV/AIDS: HOUSEHOLD COPING MECHANISMS OF THE POOR IN KENYAN SLUMS

BY

Dr. URBANUS MWINZI NDOLO, BA, MA, PhD

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DEDICATION

To my late parents I delightedly dedicate this work!! To my mum “Nzilani Ndolo”, although you left me just a few days old; presumably I were the cause of your untimely demise; I cherish and adore you!! To you dad; “Ndolo Thathi” for your love, firm leadership and generosity in the few years I lived in your warm hands, you are a hero and an icon of strength to my existence. You are my inspiration. AMEN!

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Special gratitude goes to Stephen Omondi Ndinya and Simon Ndwiga for their commitment in accompanying me in all the research sites during field work and later during data processing. Gentlemen, I greatly appreciate your extraordinary support! I thank the Vice Chancellor of The Catholic University of Eastern Africa for granting me a few months leave during data collection phase. To all our dear respondents in slums and distinguished key informants in different agencies, particularly Mr. Nicholas Makau the Programmes Coordinator, Lea Toto Programme and Prof. Mary Gitui, The chairperson Kenya AIDS Control Council and all those we shared informally, I am humbly grateful. We cannot appreciate you enough for your precious time and contribution.

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OPERATIONAL DEFINITIONS

These terms are uniquely applied to imply and present a specific meaning in this study, which may differ with the way they are expressed in other popular literature sources:-

AIDS*:* **‘**Acquired Immune Deficiency Syndrome**’ (**as it is popularly defined). In this study we define it as; ‘A state of one’s immune system being compromised after infection with HIV virus’

HIV: ‘Human Immunodeficiency Virus’ in this study is perceived as ‘A Virus that weakens ones immune system to make the body vulnerable to the AIDS attack’

HIV ***(virus) and*** **AIDS** ***(disease) impact***:

In this study this expressions denotes the way household members have been affected by either of the two diseases. Where one or more of their household members are living with the virus and/ or the disease and how this has made their lives worse or different than they were before.

Household:

A temporary and/ or permanent domestic rental and/ or own occupier dwelling unit where all family members consistently reside

Livelihoods:

A set of activities in which a family member individually or collectively with other members engage on to secure the basic necessities like water, food, medicine, shelter, clothing, education or income for their survival.

The Poor:

People who lack basic possession of a bundle of basic goods, productive assets, property or money for satisfying their basic needs. They lead a desperate life of misery and suffering mainly pushed in the slum where the cost of living is cheaper but miserable.

Economic deprivation:

Lack of opportunities and/or access to the means of production leading to desperation and vulnerability as a result of poor distribution or mismanagement of basic national resources

Poverty:

A state of deprivation and inequality, lack, deficiency or inability to acquire certain necessities required for human survival and welfare.

It could also mean denial of opportunities to graduate out of undesirable conditions of living.

Targeting procedure:

A process of identifying and selecting potential beneficiaries for assistance in an economic development assistance programme

Dependency: A state of entire reliance on another person or agency for social welfare support to sustain ones' life

Gender:

The relationship between males and females on household authority, ownership and control of resources and household chores

Policy:

A set of socio-economic principles made to guide decision making processes

Slum:

A highly populated urban informal settlement characterized by temporary dwelling shanties, lack of sanitation, safe drinking water, electricity, toilets and security where most inhabitants are squatters and generally poor.

Coping mechanisms:

Survival tricks adopted by slum inhabitants to manage the harsh living conditions in their day today lives in the slum

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List of Abbreviations/ Acronyms

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
NACC	National Aids Control Council
NASCOP	Kenya National Aids & STI Control Programme
STI	Sexually Transmitted Infections
STD	Sexually Transmitted Diseases
ARV	Anti-Retroviral
CACE	Council on African Canadian Education
NACC	National Aids Control Council
UNAIDS	United Nations Programme on HIV/AIDS
WFP	World Food Programme
CBO	Community Based Organizations
NGOs	Non-Governmental Organizations
NGDOs	Non-Governmental Development Organizations
PLPs	Participatory Learning Processes
APs	Action Plans
CASCOs	Community AIDS Surveillance and Coordination Offices
TTM	Trio-Tragedy Model
MDGs	Millennium Development Goals
IMF	International Monetary Fund
SSA	Sub-Saharan Africa
ART	Anti-Retroviral Treatment
UN	United Nations
UNDP	United Nations Development Programme
VCT	Voluntary Counselling and Treatment
US$	USA Dollars
Kshs	Kenya Shillings
GB	Great Britain
Ibid	Ibidem (In the same place)
TB	Tuberculosis

OVC	Orphaned and Vulnerable Children
IGAs	Income Generating Activities
PLWHAs	People Living With HIV and Aids
VSL	Voluntary Saving and Loaning
CDAs	Children Development Accounts
ESS	Emergency Support Services
VSLP	Voluntary Savings and Loan Programme
GBMF	Group Based Micro Finance
TST	Technical Skills Training
RFS	Revolving Fund Scheme
LSI	Livelihoods Support Initiatives
KNASP	Kenya National AIDS Strategic Plan
VMMC	Voluntary Medical Male Circumcision
PMCT	Prevention of Mother to Child infections
MTP	Medium Term Plan
SMS	Short Messaging System
WSSD	World Summit for Social Development
NPEP	National Poverty Eradication Plan
ERSWEC	Economic Recovery Strategy for wealth and Employment Creation
MTEF	Medium Term Expenditure Framework
PRSP	Poverty Reduction Strategic Paper
CBS	Central Bureau of Statistics
CIDA	Canadian International Development Agency
CCIC	Canadian Council for International Cooperation
MOH	Ministry of Health
GDP	Gross Domestic Product
MIC	Mary Immaculate Clinic
CBA	Cost Benefit Analysis
TP	Television
GF	Global Fund
FBOs	Faith Based Organizations

KAR	Kings African Raffles
MPC	Mukuru Promotion Centre
BBN	Bangladesh Business Network
DDO	District Development Officer
NRPC	Nairobi Remand Prison Clinic
PPA	Post Parenting Approach
CF	Child Fund
SoM	Sisters of Mercy
MSF	Medicins Sans Frontieres
AMREF	African Medical and Research Foundation
APHIAplus	Aids, Population and Integrated Health Assistance plus
K.U.A.P	Kisumu United Alliance Project
KENWA	Kenya Network of Women with Aids
CDF	Community Development Fund
TOWA	Total War against HIV and Aids
CACC	Community Aids Counselling Committee
CD4	Cluster of Differentiation 4 (Used in CD4 count of blood cells)
SECD	Sustainable Environment Community Development
PEPFAR	President's Emergency Plan for AIDS Relief
CARE	Corporative for Assistance and Relief Everywhere
CRS	Catholic Relief Services
KKV	Kazi Kwa Vijana
SDCOC	Society for Development and Creative Occupation of Children
SAPTA	Substance Abuse Prevention and Treatment Agency
KICOSHEP	Kibera Integrated Community Selp-Help Program
DFID	Department of r International Development
HSHSD	Health Sector HIV Service Delivery
SMH	Sectoral Mainstreaming of HIV
MARPs	Most At Risk Populations
CBHP	Community Based HIV Programmes
GSI	Governance and Strategic Information

PTWGs	Post Test Welfare Groups
CYEP	Casual Youth Engagement Programme
ToTs	Training of Trainers
PTC	Post-Test Club
VSLFs	Vocational Skills Loan Facilities
SKATS	Skills, Knowledge, Attitude, Time and Seasoning
MRC	Mombasa Republican Council
NUDF	National Uwezo Development Fund
MFFs	Micro-Financial Facilities
SACCO	Savings and Credit Co-operatives

ABSTRACT
The National silence and persistent global disinterest in HIV and AIDS is worrying! Is this an implication that a proper cure of this scourge is now discovered and readily in use? There is no doubt the World has achieved a lot of progress in control and management of this disease. However, the situation in Slum settlements in Kenya reveals centrally facts to the assumption that HIV and AIDS are no longer a health risk to the society today since ARVs are freely available. This book is an output of a study which focused on investigating how the poor in slum settlements in Kenya are affected by HIV and AIDS and their survival tricks in coping with those effects. It applied mixed research methods, where both qualitative and quantitative designs were adopted. It sought to respond to the question: How do the poor in slums cope with the effects of HIV and AIDS and how are they targeted in intervention programmes within the Government and other Public Benefit Organizations(PBOs)? Qualitative methods of data collection such as in-depth interviews guided by questionnaires, key informant discussions (KIDs), Focus Group Discussions (FGDs) and observation were predominantly employed. Both qualitative and qualitative methods of data analysis were used where specific themes generated key findings which were presented in verbatim expressions to reveal the actual feelings as presented by the respondents. Quantitative data were presented in frequency tables, percentages, pie charts, bar graphs and histograms for comparative purposes. The study found that there is little presence of the government in slums in almost all aspects like development projects, social order and social security although administrative offices of assistant chiefs and in some cases chiefs camps exist. This abnormality makes life in slums sort(s) of anarchy leading to numerous illegal activities to exceedingly thrive beyond control since as they claim; "Magava hawako" (*The Government presence lacks*). The poor who are affected by HIV and AIDS engage on different survival tricks like illegal brews, commercial sex work (exposing them to the same cycle of AIDS infections), small scale businesses and casual work in industries and households as revealed by 132 (67%) of the respondents. They live in abject poverty and inhabitable dwellings in the slum settlements (*See pictorial presentation on appendix*). Some have resulted in selling the ARV drugs to earn a living (*they are used to accelerate fermentation of illegal brews*). Theirs is vulnerable situation. Indeed, with easy availability of ARV treatment, AIDS is no longer a threat according to the inhabitants in the slums and therefore they do not care much as 168 (85.3%) in all the slums under the study observed. Some see AIDS as an advantage since they would be selected for support by PBOs, thus seek for infection as quick fix to desperate slum life as claimed 43 (22%) in Kibra slums in Nairobi. On the basis of these revelations, the study recommends a well designed proactive network and inventory of all PBOs and religious movements working in the slums since they are targeting the same clientele. This would help to avoid duplication of services and overlap of resource allocation to the same beneficiaries. There is need to clearly identify and empower HIV and AIDS orphans and grandparents who are overburdened in their old age. It would help if they were assisted to establish sustainable income generating activities to sustain their resource base as they take care of orphaned children. The youth should be targeted for technical skills based training which would not only empower them and reduce poverty but greatly address the social security concerns in slums and create harmony and peaceful co-existence of the slum inhabitants. The youth are virtually idle! This exposes them to substance abuse especially (Muguga) (*Miraa (khat) leaves*), violence and crime. If all the efforts in slums were genuine, these settlements would be transformed into middle class settlements. There is need for policy framework to deal with land tenure.

CHAPTER ONE

1.0 Introduction

This report is divided into two main parts. Part one constitutes of chapter one which captures the background of the problem, the rationale, justification, scope and delimitation of the study. It presents a conceptual framework, Contribution and limitations of the study. This part also contains chapter two which presents the literature review, which identifies the existing gaps from what other scholars have done and the theoretical framework that is relevant for this study. Part two highlights the Empirical part of the study, which presents chapter three, four and five. Chapter three contains the statement of the problem, objectives, Study questions and the methodology adopted in data collection and analysis. Chapter four presents the data analysis, interpretation and discussion of the findings. The last chapter (five) presents a summary of findings, conclusions and Recommendations.

1.1 Background of the Study

Prior to the advent of HIV and AIDS in early 1980s, Kenya had chronic levels of poverty at above 48% since independence (Bahemuka et al, 2004, 2011b). To-date, there is little empirical findings on the impact of HIV and AIDS and the coping mechanisms of different cadres of the poor in the Kenyan slums, and how they are targeted in safety net programmes. The survival tricks adopted by those affected by HIV and AIDS and how the social protection intervention initiatives affect their basic means of livelihood security specifically in slums at the household level are partially documented. Current estimates show that fewer people die daily from HIV and AIDS related ailments in Kenya (NASCOP, 2012). As National AIDS and Sexually Transmitted Control Programme (NASCOP) indicates, this drastic decline may be associated with positive changes in behaviour among high risk groups, condom use, successful campaign on reducing mother to child infections and high intake of Anti-Retroviral drugs and treatment.

By the year 2015, it is estimated that there would be much less HIV new infections and probably fewer AIDS deaths per day, and a small number of orphaned children if the current drop is consistently sustained. However, due to the current silence on the risks posed by the disease at the public domain and high rate of unfaithfulness among the married couples, these gains may be reversed and this dream of lower deaths not realised.

Although enormous resources have been invested in various strategies and prevention measures in the country in general, and in slums in particular, it's not clear how those who were already poor before the emergency of the scourge are targeted for protection along side those who are falling below the poverty line as a result of AIDS like orphans. The survival mechanisms of those who have been infected and/ or affected over the last two decades are not well documented to date either.

There is strong evident to suggest that HIV and AIDS are not only a national concern, but a global challenge with far-reaching socio-economic implications on humanity as a whole (Rugalema, 2012). In our view, in most countries; where Kenya is not an exception, HIV and AIDS have become normal concepts that do not raise eye blows any longer. Almost all the categories of people are quiet about its serious effects on society. The increasing number of new infections, especially among the married couples, AIDS cases, and deaths are overwhelming the national health care facilities and social support systems, although people are generally quiet about these challenges (CACE, 2010).

The overall implication is a serious devastation of the Kenyan economy; and widespread poverty leading to excessive dependency on desperate family members, the Government and the donor community, since most of the infected people cannot afford to sustainably acquire the recommended nutritional food stuffs and supplements even if ARV treatment and drugs are provided free of charge by the Government and other stakeholders. In the meantime, the numbers of the poor orphaned youths who are on transition from childhood continue to rise. This study seeks to investigate the impact of HIV and AIDS on the poor in slum settlements over the years; given that poverty was a serious challenge even before the emergence of the scourge particularly in Kenya.

On the basis of this backdrop, the study intends to examine the available structures and institutions to strengthen the household social support systems to cope with the pandemic on the one hand while on the other, it explores the targeting methods used by development practitioners in identification and selection of the affected people for assistance. Likewise, the study indents to further examine the efficiency of the programmes such as those supported by NASCOP and the Global Fund (GF). There is no doubt that the actual implications of the scourge on the already overburdened poor people in slums are little known, especially in Kenya.

Likewise the household tricks of survival and how they are targeted in HIV and AIDS intervention programmes remains a grey area.

The link between policy framework and practice in protecting vulnerable groups of the poor in slums are partially discussed and documented in the current poverty debate and reports. The existing literature concentrates on HIV and AIDS management, prevention and behavioural change, with little focus on how the affected and/or infected have been coping with the aftermath effects of the disease.

Key words: Kenya, HIV and AIDS impact, Slums, Economic devastation, Poverty, Gender, Household, the Poor, Livelihood security, Social exclusion, Targeting procedures, Coping mechanisms, Intervention and control programmes, dependency, and social-economic support systems, policy.

1.2 Justification and Rationale of the study

In the last decade, enormous pragmatic efforts have been committed to support Kenya's preventive strategies to reduce high transmission of HIV. At the same time, the fight against poverty has been a priority in the national development agenda since independence. In particular, there has been an expanded campaign on promotion of condom use and distribution. Lately Antiretroviral treatment is the main activity in hospitals and health clinic. There has been improved diagnostic, treatment and prevention of sexually transmitted diseases (STDs). Promotion of policy and advocacy activities; and undertaking both social and pure science research on the management of HIV and AIDS has been highly improved (NACC, 2011). However, despite all these efforts, HIV and AIDS related deaths continue to increase among married couples, more specifically in Nyanza, the Rift valley, Coastal and Eastern regions of Kenya (UNAIDS, 2011). Although the national prevalence has declined from 7.2% in 2007 to 5.6% in 2014 according to the Journal of Acquired Immune Deficiency Syndromes (JAIDS, 2014) progress report, the current poverty headcount ration of about 45.9% and estimate of 15.5 million rural and 3.3% urban poor in Kenya continues to rise. In slums poverty exceeds 53.1% (WFP, 2010). How much of these figures is contributed by HIV and AIDS complications and deaths is not known, which this study indents to investigate and expose. The nature of poverty caused by HIV and AIDS is still a gray area that we commit ourselves to examine in this study.

At the same time, the poverty characteristics as a result of the HIV and AIDS are partially known and documented. Most studies have concentrated on awareness creation to influence behavioural change, testing and prevention of further infections in different age groups. To what extend HIV and AIDS influences the poverty situation in different sectors of society are little known. Besides, the existing household coping strategies and how social funds and other forms of safety nets target the poor who have been affected by the scourge over the years in slums is the main focus of this study. The policy framework on the type of poverty caused by HIV and AIDS and how different stakeholders implement those policies and their performance are still speculative. All these aspects justify the need for this in-depth study in order to avail the necessary information and design preventive measures respectively; that could be used to sustainably address the challenge. Although HIV and AIDS may be on its downward trend, even after it is fully controlled, those who became poor due to its consequences need socio-economic support to rejuvenate and cutch-up with the rest of the other people in society.

1.3 The Significance of the Study

An analysis of the implications of HIV and AIDS on poverty is important in understanding the nature of poverty caused by the disease in slums and how such poverty could be addressed alongside the HIV and AIDS interventions among the youth. The findings would help in setting up sustainable solutions to the global outcry on the devastating impact of the pandemic on the poor in general and in Kenyan slums in particular. It highlights innovative strategies of implementing and coordinating the fight against poverty which is caused by the spread of the disease, and the nature of practical interventions that could be adopted to reduce further human suffering and impoverishment in slums and elsewhere in the country.

More specifically, the findings of the study would serve as a revelation of the real life experiences of the poor in slum settlements (communities) and their survival mechanisms. This would be an eye opener to policy makers and Government officials on the nature of resources and skills required to address HIV and AIDS related poverty. It would inform other stakeholders like civil society Organisations and the donor community on the nature of projects they could engage on to supplement the Government's efforts in eradicating HIV and AIDS resulting poverty. The findings would used to set targeting strategies for HIV and AIDS related poverty for different categories of the affected people in society.

It would serve as a basis for designing policy framework for the governments, NGOs, CBOs and Medical practitioners on the nature of poverty, gender needs and advocacy required if HIV and AIDS prevention measures would have long-term positive effects without influencing poverty increment. The study would be useful to the donor community on which development initiatives may require their support in order to address the challenges faced by those who live in slums to contain HIV and AIDS related poverty without increasing the level of dependency on the government and the donor community.

1.4 Scope of the Study

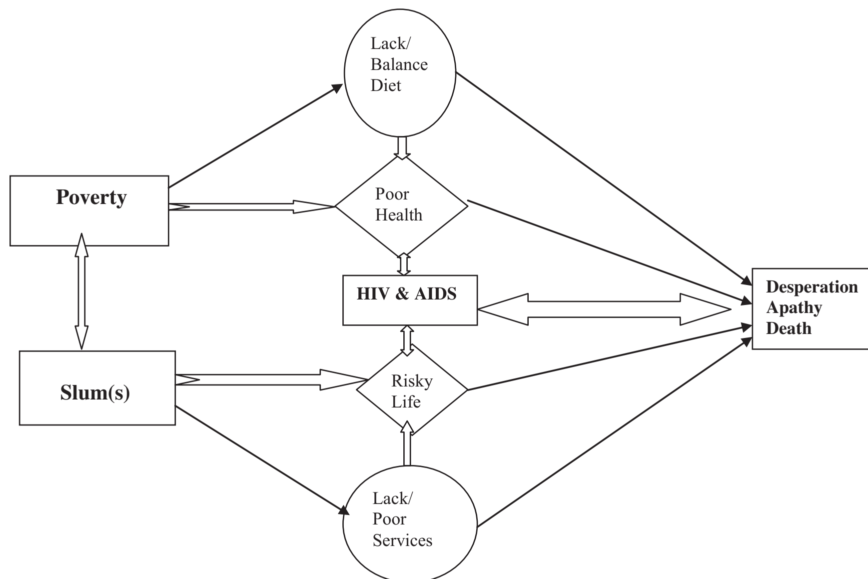
The study targeted four selected informal settlements in Kenya. Kibera and Mukuru Kayaba in Nairobi were selected due to their proximity to the researcher's work place, the Catholic University of Eastern Africa. Besides Kibera is the largest informal settlement south of Sahara and the most congested area inhabited by the poorest of the poor. Mukuru Kayaba is next to industrial area which provided valuable insights on the nature of livelihoods adopted by people working as casual workers in factories. The other two namely; Nyalenda in Kisumu (Nyanza county) and Bangladesh in Mombasa county in the coastal region were selected to represent the second and third major cities in the country respectively. The slums were selected on the basis of the HIV and AIDS prevalence rate, population size and poverty incidence. The study targeted a sample of 250 respondents. The main units of observation were those who are infected, as well as those who are affected by HIV and AIDS in different ways. However the researchers were able to access 197 respondents from the general residents in the slum, and 18 key informants drawn from public administrators, health officers, Development officers, Women representatives, religious, youth and NGO leaders. In total 215 respondents participated in the study.

1.5 The Conceptual Framework

1.5.1 The Trio -Tragedy Model (TTM)

Different assumptions and theoretical perspectives have been advanced to explain certain aspects of HIV and AIDS and poverty independently. This study applies the **Trio-Tragedy Model (TTM)** (*researcher's own illustration*) to demonstrate how the HIV and AIDS pandemic and poverty not only weakens the household social livelihood security systems, but also pushes the

household members beyond the poverty line mainly in slums leading to apathy, desperation and extreme suffering of the household members whose ultimate result is death.



Source: Researcher's own illustration of study Variables, 2018

Lack of permanent sources of income in slums makes the household members engage in risky activities that expose them to HIV and AIDS a circle whose agony ultimately leads to crime and/ or death. The scenario further exposes the household members to other social risks including; withdrawal from school or college after children lose a bread winner. This implies that children and dependants have no sustainable means of livelihood. Young girls and boys engage on activities like prostitution, drug abuse, theft and illegal brews to sustain the family. The shock of losing a breadwinner and/or both parents to AIDS for example, reverses the household poverty cycle trends reaping-off all the previous gains and progress made earlier almost instantly in slums. Where households were wealthy, they relocate into the slums where the cost of living and means of survival are relatively cheaper. However, the instant transition makes the family extremely poor since most of the resources had been spent in sustaining the nutritional upkeep of

the HIV and/ or AIDS patient even if they were under ARV therapy and treatment. This trend makes the household bounce back below the poverty line to a state of defencelessness and misery. The basic means of survival are pushed beyond the normal cyclical oscillation above and below the poverty line, leading to vulnerability and abject poverty in the long-term.

At the same time other structures of the economy for instance, health, employment, trade; leadership and education are greatly affected. The process therefore is likened to a three ford tragedy thus (*Poverty* ⇔ *slum life* ⇔ *HIV and AIDS* ⇔ *Death)*.

The previous development initiatives have been fighting the former (Poverty) but a strategy to fight the trio challenges including the latter (HIV and AIDS) concurrently with the effects of (slum life) was the focus of this study. If this approach is effectively implemented, the fight against the three social challenges would be consistently won within the economic and social pillars of the vision 2030 which focuses on improving the prosperity of all Kenyans and drastically reducing the effects of AIDS and poverty. This would be in line with the Millennium Development Goals (MDGs) focus as well.

1.6 Delimitations of the Study

The study does not focus on HIV and AIDS as a diseases per se (which in our view is highly investigated and documented, but it focuses on '*the effects of HIV and AIDS on the poor and their coping mechanisms in slums in Kenya'*. Likewise the study did not target the whole slum area or every inhabitant in the slum but only those who were affected by the disease in one way or another in order to understand how they were coping and the kind of support systems exists in the slums for them. We had only six to nine months to collect data, which was not adequate to move to all the regions and conduct thorough in-depth interviews combined by structured and participant observation. The biggest delimitation for this study was inadequate resources to higher more research assistants to reduce the burden of data collection.

1.7 Organization of the Report

The report is organised in five (5) chapters. Chapter one consists of the introduction, objectives, the statement of the problem, guiding questions, justification, limitations and the contribution of the study, including various methods of disseminating the findings to different stakeholders in the country. Chapter two concentrates on detailed review of the related literature on the main issues under investigation. This highlights what other researchers have done to identify gaps to

be bridged in this current study and similarities of thought where possible. Besides, exploration of books, development reports, government session papers, local, regional and international civil society HIV and AIDS and poverty reports are presented. In particular the targeting procedures applied in these programmes are carefully evaluated, to identify their performance, effectiveness as well as the targeting errors encountered. This chapter also presents the theoretical framework relevant for this study namely:- The social exclusion theory, the systems and dependency theory. Chapter three dwells on the main methodology used in data collection, identification and selection of the study area, the study design, sampling techniques, the sample size, and the data collection instruments and their viability. Chapter four (4) presents data analysis procedures, interpretation and discussion of findings and presentation of data. While chapter five (5); presents a framework of the conclusions and recommendations on the way forward and practical interventions and some potential areas for further research.

1.8 The research Team

A broad-based team of research assistants comprising of sociologists, Economists, statisticians, Social workers, were deployed during data collection accompanied by the principle researcher. Each graduate student was accompanied by two (4) fourth year undergraduate students to make a total of four teams at least one for each study site. The principle researcher accompanied each team during fieldwork. The teams were initially trained on household survey interviewing techniques, data recording, probing and coordination of Focus Group Discussions sessions and Key informants sessions. Some of the NGOs working in the slums provided the basic link between the researchers and the target communities members and groups. A precise timeframe to guide Participatory Learning Processes (PLPs) in the focus-group discussion sessions were drawn after the reconnaissance survey.

1.9 Dissemination of results

The findings would be presented in an initial inter university workshop for academic procedural verification and critique. A series of leader's workshops in each study area would be organized much later through the county government development and planning offices to share the findings and decide on viable Action Plans (APs) for implementation of results by different stakeholders in each slum. This would draw participants from the country Community AIDS Surveillance and Co-ordination Offices (CASCOs) and the departments of culture, social

security and development planning that deal with poverty and community empowerment. The local communities and other stakeholders would be reached through CBOs and county government administrative structures. Their input at that level will inform the country development planning team about the necessary plan of action and influence the national policy at project partners networking forums with donors. Some copies would be forwarded to the University libraries, national archives for potential users from other areas. The findings would be made available in research, media, and church institutions, through the national HIV and AIDS co-ordination board, libraries, and the ministry of health for policy considerations. Preliminary results would be published in the local dailies for awareness creation as well as posting them in the internet for access to a wider spectrum of readers.

1.10 Work-plan and Schedule of Activities

Activity/ Event	Duration	Proposed Period
Reconnaissance Survey	3 Weeks	3 weeks in February 2011
Development of Data Collection instruments	2 Months	Between March and April, 2012
Acquire Research permits and train research assistants	2 Months	May – June 2012
Data Collection	9 Months	July 2012 to May 2013
Data processing, Analysis, Interpretation and presentation	3 Months	June to September, 2013
Presentation of a draft research Report and feedback	5 Months	In October and February 2014
Defence seminar/ workshops	1 day	June, 2014
Submit Final Thesis	1 Day	November, 2014
Tentative Completion	Graduation	January/ February, 2015

1.11 Limitations of the Study

1. Poverty is a dynamic and complex phenomenon just like HIV and AIDS. The study had difficulties in identifying poverty as a result of HIV and AIDS compared to poverty caused by other aspects like hostile environment, low economic growth, structural reforms, unemployment and corruption especially at the slum settlements. This challenge was resolved by adopting a

before-after historical comparative approach. We enquired about the conditions and material wellbeing of each household before they were affected by HIV and AIDS and compared with the current situation after illness or death of a household(s) member(s) to distinguish the nature and levels of need.

2. HIV and AIDS are still stigmatising even though people are becoming more silent about them. Most respondents hesitated to contribute to the debate in fear that they might be assumed to have the disease if their family member(s)/ spouses died of the disease as well. Surprisingly, more people in the slums were freely discussing their health conditions and HIV status, although some used this in expectation of material support. This prevailing awareness and openness helped most households to discuss their family conditions without fear for stigmatization. Mostly respondents were counselled prior to the interviews that the study did not indent to identify or disclose peoples' HIV and AIDS status or any other health complication. It indented to examine how the poverty situation had worsened or improved as households addressed HIV and AIDS effects among their members. This gave them confidence to participate in the interviews.

3. Some households openly claimed to have been affected by HIV and AIDS in different ways in anticipation for sympathy and material assistance. To resolve this challenge we informed the respondents that the researchers were not able to provide any material support or pay for any information provided, but were seeking for their voluntary contribution and participation in the study.

4. Poverty, HIV and AIDS and life in slums are broad social aspects that require a lot of time, labour force and finances to adequately explore and analyze. A smaller sample size and geographical coverage in each study area was selected after the reconnaissance survey to minimise the problem of time and cost during data collection since the study was more qualitative in nature which involved direct interaction and in depth interviews with the community members.

5. The study might have suffered certain degree of biasness since some respondents might have provided false information in expectation of assistance. In this case, some error was applied

during data analysis to cater for any information that might have been implied out of context on the subject matter.

6. Some youths demanded for a token of appreciation (cash payment) in order to provide information. To resolve this challenge, we informed them prior to our interviews that we did not intend to pay for information and requested for their voluntary contribution. The adamant ones were excused not to participate.

7. It was insecure to visit some parts of the slums on our own. We sought the assistance of local administrative slum (Nyumba kumi elders)(the ten household elders) and youth leaders who were familiar with the area and were well known to the local community to accompany us. Their presence made most respondents open up and interact freely with the researchers.

8. Most youths spoke sheng (mixture of Kiswahili and English). Our research assistants and guides assisted in interpretation of some of the expressions to capture the meaning and implications of what was presented in youth focus group discussions.

9. Filth environment were sometimes a shocking nightmare especially after it had rained. Since most inhabitants were not using gum boots, we opted to use our normal shoes even in muddy areas to identify with the local people.

10. Suspicion: At times we had to take time to establish good rapport with the local people through their leaders to be able to interact with slum dwellers. We participated in local church events. Occasionally, we had to clarify that we were not working for security agents or government officials to get information, especially when we met new respondents.

11. Time Control and High expectations: In some cases, respondents continued with discussions in expectation that we would provide immediate solutions to their challenges. However, we informed them that our findings and recommendations could affect policy in the long run but not immediately as they anticipated.

CHAPTER TWO

2.0 Literature review

This chapter analyses insights presented by other scholars on the evolvement of slums in the world, and how HIV and AIDS have influenced the living conditions of the poor in the informal settlements in Kenya and beyond. It concludes with a critical examination on how the social exclusion, dependency and systems theories explain the interplay of social economic linkages on both interventional efforts and policy framework to spearhead human transformation and universal economic growth.

2.1 Evolvement of Slum settlements in the World

As observed by Udjo (2011), there is a higher population growth rate in Africa compared to other continents. This demographic factor raises key concerns on how the Millennium Development Goals (MDGs) in the continent would be realized; given that over a half of that population lives on less than a dollar a day. The poverty situation has been exuberated by HIV and AIDS pandemic more specifically in slum settlements where majority of the inhabitants are marginalized household members.[1] The fast urbanization growth rate and high rural to urban migration in poor countries like Kenya are partly the causes of the ever expanding slum settlements as Owusu et al (2012) asserts.[2]

Huchzermeyer (2012) identifies key features that distinguish a slum from other urban settlements. The slums lack land tenure. People live in informal rental houses and shanties, and high levels of insecurity are evident, poor and/or inexistence of basic infrastructural facilities like water, electricity, toilets and social amenities. There are high population densities, poor living conditions and lawlessness among many others.[3] To ascertain this argument Ganesh (2011) observes that;

"A slum is a heavily congested and often poorly built temporary human settlement, mostly with no security of tenure and prone to antisocial activities, which is

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[1] E.O. Udjo, *Demographic projections of Africa's population for the period 2000-2020 taking account of HIV/AIDS and its implications for development*. Southern African Business Review Volume 12 Number 3 2011.

[2] Owusu George et al, *Slums of hope and slums of despair: Mobility and livelihoods in Nima, Accra*. Norsk Geografisk Tidsskrift-Norwegian Journal of Geography Vol. 62. Oslo. ISSN 0029-1951. DOI 10.1080/00291950802335798. (2012). Pg. 180

[3] Huchzermeyer Marie, *Enumeration as a grass root tool towards securing tenure in Slums: Insights from Kisumu, Kenya*. Urban Forum (2011), Springer Science + Business Media B.V Pg 271

characterized by shortage of safe drinking water, inadequate power supply, lack of proper sanitation and scarce medical and social facilities."[4]

However in Kenya there is no official definition of the term slum or even informal settlement as they are commonly referred to. Therefore they are used interchangeably (HABITAT, 2010A: 219). On this basis city authorities view slums as areas that lack basic services and infrastructure according to Hurskainen, et al (2013). Historically human settlements started around the lake regions, river banks and at places with adequate fresh water sources. This was an attempt by people to search for better opportunities driven by instinct for survival and satisfaction in life.[5]

The emergence of slums in Kenya according to Werlin (2011) was as a result of racial discrimination under colonialism, where majority of the poor native African population settled since their income levels as casual shamba boys (gardeners) and cleaners in the white settler's suburbs could not pay for a decent house. Other scholars among them Ganesh (2011) see accumulation of high international debt burden as a contributing factor due to low economic growth. They further argue that besides unemployment and low salaries for the lower categories of employees, slums were intensified by Structural Adjustment Programs (SAPs) which were imposed by the World Bank and the International Monetary Fund (IMF), a situation that has been worsened by inadequate foreign aid and bad governance.[6]

As Obudho (Urban Quarterly Centre) and Zwanenberg observes, development of slums in Kenya is largely influenced by the fact that people who lived in them during the colonial period constituted the majority of the new entrants in the city which served as the main stop over as people sought for employment.[7] Further Ganesh (2011) cites low remuneration for industrial casual workers in construction and engineering sides as major contributing factors for the recent

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[4] Ganesh P. Pokhariyal, *Models for understanding social problems in slums*. International Journal on World Peace Vol. XXII No.2 June 2011. Pg 59-62

[5] Hurskainen, P. and P. Pellikka, C*hange detection of informal settlements using multi-temporal aerial photographs – the case of Voi, SE-Kenya*. Department of Geography, University of Helsinki, Helsinki, Finland, 2013.

[6] Werlin Herbert, *The slums of Nairobi explaining urban misery*, World Affairs, Vol. 169 No. 1 Summer 2011. Heldref Publications. Pg 40

[7] R. Van Zwanenberg, *History and theory of urban poverty in Nairobi the problem of slum development*. Discussion paper 139, Institute for Development Studies University of Nairobi, 2010. Pg 3

expansion of informal settlements coupled with the high population growth in urban places in Kenya as the main cause of slum settlements.[8]

Despite the liberation from the colonialism, efforts by the Kenyan government to re-settle the landless citizens through land adjudication programme did not meet the demand for settlement as asserted by Karanja, et al (2012). This was exacerbated by insufficient planning which led to expansion of the existing slums and emergence of new ones. In addition the slum areas were not officially recognized with most urban areas maps almost universally displaying slums as unoccupied free land. Worst still, some slum areas that fall under public land utilities were allocated to the politically correct personalities as rewards for their political patronage especially during the regime of President Kenyatta (first president of Kenya) and Moi era (Second president of Kenya).
However to date things have changed with the government of Kenya adopting a more accommodative approach to slum settlements especially after the halting of slum demolition and further establishment of slum upgrading programme of the then, city council in the year 2008 a programme that was active in Kibera and Mathare slums.[9] Currently there is a concerted involvement of the National Youth Service (NYS) to give the slum a face-lift under Kazi kwa Vijana initiative funded under the Ministry of devolution and planning. This agenda is still not clear whether it would be extended to other slums in Nairobi and other Towns. Marmot (2010) firmly noted that the poor in slums are vulnerable to more serious health risks due to poverty which leads to inadequate nutritious foods, poor shelter and sanitation and lack of safe drinking water. On top of these, she argues, the outbreak of HIV and AIDS claims a high number of the poor in informal settlements in Kenya than any other disease.[10]

2.1.1 An overview of HIV and AIDS in Kenyan Slums

Generally, people in Kenya are now quiet and there is a general assumption that HIV and AIDS are not a threat anymore! In fact people have gone back to their old free sexual interaction

[8] Ganesh P. Pokhariyal, *Models for understanding social problems in slums*. International Journal on World Peace Vol. XXII No. 2 June 2011. Pg 61-64
[9] Karanja Irene Wangari and Makau Jack, *An Inventory of the Slums in Nairobi*. Available online at: www.irinnews.org/pdf/nairobi_inventory.pdf. Accessed on 13th February 2012. Pg 10-12
[10] Marmot Michael, *Health in an unequal world*. Lecture presented at the Royal College of Physicians, London, UK, on Oct 18, 2010, and published in *Clin Med* 2006; 6: 559–72. Available online at: www.thelancet.com Vol 368 December 9, 2010. Pg. 2081-82

behaviour. Although several measures and enormous resources have been invested on the fight against HIV and AIDS pandemic, the scourge remains a serious threat to the social welfare, human progress, social stability and food security among the slum inhabitants as revealed by Agatha, et al (2011).

As a result, it has had adverse effects on social and economic development of the affected people, since they live on illegal land where infrastructure is inexistent. These challenges are attributed to increased household expenditure on medical care, decreased ability to work and higher demand for time to provide constant care to people living with HIV and AIDS.[11]

In some instances, children are compelled to terminate their education as a result of socioeconomic challenges posed by HIV and AIDS considering that even the relatives who have adopted them, may be living with the disease hence not being fully productive and supportive. Luckily, the free antiretroviral therapy and treatment seems to have worked magic, but the high cost of nutritious food stuffs remains a big challenge to the poor households in slums. Prolonging life through ARVs prolongs suffering for those affected to a certain extent. In our view, this scenario accelerates the downward spiral trend which increases poverty at the household level of the affected and/ or infected household members in slums. Generally, there is an assumption that with ARV treatment, all is well. In some instances where there is lack of strong traditional support system, some families end up sliding further into destitution and extreme poverty.[12]

The recent estimates by the United Nations Agency for the control and prevention of HIV and AIDS (UNAIDS) indicate that the Sub-Saharan Africa (SSA) bears the highest burden of the disease according to Kabiru, et al (2011). The report shows that 66 percent of all HIV cases worldwide (23 out of 35 million HIV cases) live in SSA, with 2.4 out of all 4.3 million estimated new HIV cases globally in 2011 (i.e., 65 per cent of all new infections) also occurring in SSA countries. Shockingly, about a half of the new infections are among married couples.[13]

However it is important to acknowledge that the prevalence of HIV is not uniform in SSA especially in the East Africa region where the trend has been going lower as Kimanga

[11] Agatha Christine et al, *Expenditure patterns on food and non food items in HIV/AIDS affected and non affected households in Kisumu District, Kenya*. African Journal of food agriculture nutrition and development, Volume 10 No. 4 April 2011. ISSN 16845374. Page 2346

[12] Ibid Page 2346

[13] Kabiru W Caroline et al. *HIV/AIDS among youth in urban informal (slum) settlements in Kenya: What are the correlates of and motivations for HIV testing?* BioMed Central Public Health 2011, 11:685. Available online at: http://www.biomedcentral.com/1471-2458/11/685. Pg 1-2

(2014) further notes. In our observation, this could be attributed to the concerted response by both the governmental and non governmental agencies through the Global Fund (GF) initiative and other local and foreign donor efforts.

For example in Kenya, the number of cumulative daily AIDS related deaths has dropped from around 150,000 in 2007 to about 85,000 in 2010, and less than 25,000 in 2014. This scenario could be attributed to the combined effect of 'survival bias' and an increase in the number of HIV positive individuals who are put on Anti Retroviral Treatment (ART) and high public awareness about the disease.[14]

With similar sentiments, Fr¨olich (2010) observes that without an effective vaccine to stop HIV transmission and with very expensive medical treatment, information campaigns in vernacular media stations still plays a major role in curbing the scourge. They are cost effective in reducing new infections because people understand the dangers of HIV and AIDS better.[15]

2.1.2 The State of Poverty in the Slums in Kenya

Despite the enormous efforts by the slum dwellers to generate moderate income individually and/or in self-help groups to improve their quality of life and standard of living, many scholars claim that HIV and AIDS has made livelihoods in this settlements worse as noted by Owusu, et al (2011). Besides the poor sanitation, people purchase items in small quantities for each meal depending on their daily income levels.[16] This argument creates a gap that this study indents to explore to what extent this lifestyle is caused or aggravated by HIV and AIDS among other aspects and therefore how do the poor manage the situation. Kenya like other developing countries still faces the challenge of emerging new slums. Unlike the past, smaller towns in the counties now have emerging slums while at the same time they are striving to achieve the Millennium Development Goal number one on; (Eradicating extreme poverty and hunger) which is a common phenomenon in all the poor countries.[17]

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[14] Ibid. Pg 1-2

[15] Fr¨olich Markus and Vazquez-Alvarez Rosalia. *HIV/AIDS Knowledge and Behaviour: Have Information Campaigns Reduced HIV Infection? The Case of Kenya*. 2010, Pg 87-8

[16] Owusu George et al, *Slums of hope and slums of despair: Mobility and livelihoods in Nima, Accra*. Norsk Geografisk Tidsskrift-Norwegian Journal of Geography Vol. 62. Oslo. ISSN 0029-1951. DOI 10.1080/00291950802335798. (2011). Pg 180

[17] Ministry of Planning and National Development, *Millennium Development Goals in Kenya Needs and Cost*. 2012.

According to Ndinya (2010), there are serious concerns in slums in relations to social safety, unemployment, inadequate health facilities due to overpopulation arising from urbanization. As a result of the worsening economic hardships, most slum residents result to desperate tricks of survival such as hawking (selling small items on the streets), touting at the bus parks, begging, and squatting at bus terminals. Child prostitution by under-age school going girls and petty stealing by the boys are common practices in the slum. All these children abuse drugs. If these practices are not effectively controlled, they might lead to serious insecurity and spread of new HIV infections among the older men who target younger sex partners, with a belief that they would be cured since the kids are pure. Quite often, the most vulnerable are the young women who tend to avail themselves for cheap commercial sex for as low as Kshs. 100/- (US $ 1.2) exposing themselves to the risk of contracting HIV and AIDS among other Sexually Transmitted Infections (STIs).

This problem does not affect the young people alone. It exposes the whole population to hazards because they have inadequate funds to provide adequate nutritious food content to their families and seek for better healthcare services at the same time.[18]

Joseph, et al (2012) concurs with these views when they assert that poverty and gender are inextricably intertwined. They strongly affirm that the poor women are most susceptible to new HIV infections since their bodies are perceived as a ready resource for commercialization. To confirm this aspect they highlight the interconnectedness of poverty, gender and HIV and AIDS as quoted below:-

> *"Two out of three women in the world presently suffer from the most debilitating disease known to humanity. Common symptoms of this fast-spreading ailment include chronic anaemia, malnutrition, and severe fatigue. Sufferers exhibit an increased susceptibility to infections of the respiratory and reproductive tracts. And premature death is a frequent outcome. In the absence of direct intervention, the disease is often communicated from mother to child, with markedly higher transmission rates among females than males. Yet, while studies confirm the efficacy of numerous prevention and treatment strategies, to*

[18] Ndinya O. Steven, *The African Traditional Health Therapies, Their Therapeutic Values and Effects on Health Care in Nairobi Kenya*. Unpublished Bachelors Research Project, St Elizabeth University, Bratislava Slovak, 2010.

date few of these complications have been vigorously pursued. The disease is poverty (Jacobson, 2005:3) as quoted by Joseph et al (2012)."[19]

The findings of Marmot (2011) acknowledge this argument that in both the poor and rich countries, poverty is more than just lack of income; which had been cited in the World Development Report, 2010. The World Bank, 2012 emphasised that poverty largely involves lack of opportunities, empowerment and dignity for the poor which is predominantly evident in the Kenyan slums. These challenges require an all inclusive approach to address poverty alongside the fight against HIV and AIDS and gender empowerment in order to strengthen household livelihood securities.[20] The current study intends to design an approach that could bridge this duo social gap.

2.1.3 The Survival Mechanisms of the Poor in Slums

Nyamongo (2010) observes that the poor in slums engage on almost any activity that would yield to money however little they earn. These activities range from hawking, production of traditional brews, cooking food stuffs by the road sites and to sale of cannabis. In Kenya the rich own the shanties (housing units in slums) and whole sale shops but live in the middle class estates adjust to the slums for easier collection of rent payments. Surprisingly 8% of the slum dwellers are not poor either (McCombie, 2009). Those infected with HIV and AIDS survive on ARVs and food rations from the numerous health centres run by religious organizations and NGOs in the area. Occasionally patients administer self-treatment using cheap locally acquired traditional herbs due to poverty (Nyamongo, 2002a).[21]

The poverty situation in slums is worse due to the arguably the bad economic circumstances affecting the developed countries leading to reduced donor aid on social development programmes as noted by Dodoo, et al (2013). In addition, Africa lacks strong inter-governmental economic initiatives for regional development investment on health and poverty

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[19] Joseph Collins and Bill Rau, *AIDS in the Context of Development*. UNRISD Programme on Social Policy and Development. Paper Number 4. ISSN 1020 8208. December 2012. Pg 5-6

[20] Marmot Michael, *Health in an unequal world*. Lecture presented at the Royal College of Physicians, London, UK, on Oct 18, 2011, and published in *Clinical Medicine* 2011; 6: 559–72. Available online at: www.thelancet.com Vol 368 December 9, 2011. Pg. 786

[21] Amuyunzu Mary Nyamongo and Isaac K. Nyamongo, *Health Seeking Behaviour of Mothers of Under-Five-Year-Old Children in the Slum Communities of Nairobi, Kenya*. Anthropology & Medicine Vol. 13, No. 1, April 2010, pp. 26-7.

reduction.[22] Similar sentiments are highlighted by the United Nations Development Programme (UNDP, 2010 and UNAIDS, 2010c) who argue that poverty aggravates other factors that heighten the susceptibility of women to social risks as noted below:-

"A lack of control [by poor women] over the circumstances in which forced intercourse occurs may increase the frequency of intercourse and lower the age at which sexual activity begins in girls. A lack of access to reliable health services may leave simple sexual infections untreated in rural areas. Malnutrition not only inhibits the production of mucus but also slows the healing process and depresses the immune system in such women (UNDP, 2010:4, see also UNAIDS, 2010c)."[23]

They further argue that unequal social and economic positioning between the genders is essential in determining health outcomes. Therefore the scale of income differences in a society is one of the most powerful determinants of health standards in different countries hence influencing health through its impact on the general social standard of living. Poverty is therefore a contributor of increased HIV transmission and an exacerbating factor towards the increase of full AIDS infections as indicated below:-

> *"The experience of HIV and AIDS by individual households and poor communities can readily lead to an intensification of poverty and even push some non-poor into poverty. Thus HIV and AIDS can impoverish people's socio-economic livelihoods systems in such a way that intensifies the epidemic itself where awareness levels are much lower."*[24]

Not only have the women experienced challenges relating to HIV and AIDS but also the greatest losses and burdens associated with economic and social crises and trauma caused by loss of family members. Majority of the married women quite often have little control over the sexual behaviour of their husbands in the African traditional set up according to Joseph, et al (2010) who notes that gender bias in the African cultural systems permeates the HIV and AIDS related poverty suffering among the female gender.[25]

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[22] Dodoo F. Nii-Amoo et al, *Urban-Rural Differences in the Socioeconomic Deprivation Sexual Behavior Link in Kenya*. *Social Science Medicine*. 2013 March ; 64(5): 1019–1031. Pg 1

[23] Joseph Collins and Bill Rau, *AIDS in the Context of Development*. UNRISD Programme on Social Policy and Development. Paper Number 4. ISSN 1020 8208. December 2010c. Pg 5-6

[24] Ibid Pg 5-6

[25] Ibid Pg 19-20

2.1.4 Socio-economic support systems for the poor living with HIV and AIDS in Slums

Voluntary Counselling and Testing (VCT) units are some of the support systems that are readily visible almost everywhere in the Kenyan slums as Kabiru, et al, (2011) ascertains. There is no doubt that these facilities are essential in making the people in slum areas know their HIV and AIDS status so that they could strive to live a healthy life and protect their loved ones.[26] In these centres, the poor household members are identified for other types of assistance like food rations and door to door surveillance on ARV adherence.[27]

Unlike in other settlements, there is high cohesion and enhanced family therapy in slums where household members voluntarily provide health information to one another.[28] In the absence of the Government systems in slums except the chiefs' camps, Non-governmental Organizations (NGOs), Community-Based Organizations (CBOs) and Faith Based Organizations (FBOs) have projects on education, social awareness and home-based care in all the slums as noted by Joseph, et al (2010).[29] Ndinya and Tumushabe highlight the similar sentiments, Ndinya (2012).[30] And Tumushabe (2009).[31]

2.1.5: The Nature of Slum Livelihoods in Kenya

The informal settlements within Nairobi and elsewhere in Kenya, popularly referred to as slums are often distinguished by the fact that they are located on government land. They are highly congested with small (bed sitter) units that are often shared by a number of occupants in order to equally share the cost of rent which ranges from Kshs. 400/- (US$ 5) to 2000/- (US$ 25) depending on the locality and type of house finish. Houses are generally temporary shanties whose walls are made of poles and mud and grass, polythene or iron sheet thatch. Few of the houses have cement floors. Slums are commonly characterized by poor sanitation, poorly build

[26] Kabiru W Caroline et al. *HIV/AIDS among the youth in urban informal (slum) settlements in Kenya: What are the correlates of and motivations for HIV testing?* BioMed Central Public Health, 2011, 11:685. Available online at: http://www.biomedcentral.com/1471-2458/11/685. Pg 2

[27] Ibid Pg 2

[28] Fr¨olich Markus and Vazquez-Alvarez Rosalia. *HIV/AIDS Knowledge and Behaviour: Have Information Campaigns Reduced HIV Infection? The Case of Kenya, 2010,* Pg 89

[29] Joseph Collins and Bill Rau, *AIDS in the Context of Development*. UNRISD Programme on Social Policy and Development. Paper Number 4. ISSN 1020 8208. December 2010. Pg 25-38

[30] Ndinya O. Steven, *Desire for children and the Unmet Socio-Cultural Needs among the HIV Positive couples: A Case Study of Nyando District, Kisumu County*. Unpublished Masters Research Thesis, St Elizabeth University, Bratislava, Slovak, 2012.

[31] Tumushabe Joseph, *The Politics of HIV/AIDS in Uganda,* Social policy and development paper Number 28. August 2009. United Nations Research Institute for Social Development. ISSN 1020-8208. Page 15-24

and un-kept pit toilets. Lack of electricity and safe drinking water, with scanty commercial water points, where a twenty litre tin costs between Kshs. 10/- (US$ 0.15) and 20/- (US$ 0.25). The surroundings are quite insecure even for the local inhabitants. Informal businesses including traditional brews and a range of assorted drugs are readily available as Aubre (2009) asserts. The existing infrastructural facilities are poorly established and equipped such as health care centres, schools and other public utilities including security systems.[32] Two such informal settlements within Nairobi include Kibera and Mukuru Kayaba. Mukuru Kayaba is situated within Makadara division together with other informal villages (about 10 of them). It is adjacent to a relatively affluent South B settlement which houses mainly the middle class and the larger industrial area[33]. Kibera on the other hand is the largest informal settlement in Kenya and also among the eight informal settlements as Karanja and Makau indicated in an inventory mapping exercise for Pamoja Trust an indigenous NGO involved in land rights advocacy in Langata division. Kibera borders Langata and Karen suburbs which are often referred to as Karengata.[34]

Most residents in slums use shared toilets, bath rooms (where they exist) and pit latrines since the facilities are much fewer than the demand. The areas are not connected with sewer lines and the waste water is drained through small drainage channels that deposit them to the nearby rivers[35]. Additionally, it is reported that where sewage lines pass through the settlements, the residents make illegal connections to sewer inlets that are used as clean water for sale.
They also make illegal connections to the power lines that pass near the settlements and charge their neighbours for the electricity consumption. Some youths are paid to scoop the human waste using tins and bear hands and pour them in the rivers using hand carts. According to Talukdar and Potter (2009) the infrastructural challenges within the informal settlements are attributed to the government's failure to legally allocate the land to the members of the public and incorporating them in city development plans.[36]

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[32]D. M. MUVENGI.: *Poverty, church, and development in Kenya: A case study of Kibera slums in Nairobi*, 2011, 47-50p.
[33]AUBRE .D.: *Community based sanitation entrepreneurship in Mukuru and Korogocho informal settlements, 2009*,1p.
[34] I.W. KARANJA - MAKAU. J.: *An Inventory of the Slums in Nairobi, 2008*, 92-115p.
[35](Ibid, pg. 95-97)
[36]TALUKDAR.G.D-POTTER.C.: *Inside Informality: Poverty, Jobs, Housing, and Services in Nairobi's Informal Settlements, 2009,* 12p

Under these conditions, those living with HIV and AIDS are more vulnerable to opportunistic infections compared to those who live in better environments. Notably in slum areas is high crime levels associated with the general lack of effective policing by government security personnel which leads to frequent cases of violence and murder according to Oxfam GB. [37] Residents in informal settlements are mostly tenants who lease or rent rooms. The landlords and the structure owners leave in better estates that are more secure and well lit. Residents have no ownership title deeds for the lands they occupy and are thus highly vulnerable 2011[38].

Slum residents have to content with food insecurity, where essential food products are generally in short supply and there are high prices for commodities, Ganesh,[39]. This is associated to the high rates of poverty and unemployment or lack of reliable sources of income as most scholars observe Abdulla,[40], Karanja and Makau,[41] and Since most slum dwellers are poor, traders are not willing to supply goods where their returns are minimal Klopp,[42]

[37] OXFAM GB.: *Urban Poverty and Vulnerability In Kenya Background analysis for the preparation of an Oxfam GB Urban Programme focused on Nairobi*, 2010, 15-27p.
[38] D. M. MUVENGI.: *Poverty, church, and development in Kenya: A case study of Kibera slums in Nairobi, 2011,* 41-43p
[39]GANESH.P: *Models for understanding social problems in slums, 2011*, 73p.
[40]ABDULLA. A et al: *Towards Sustainable Vulnerability Reduction for Kenya's Ultra-Poor living in Urban Slums, 2011*, 6-7p.
[41] W. KARANJA - MAKAU. J.: *An Inventory of the Slums in Nairobi, 2010*, 11, 62, 130, 205p.
[42] KLOPP.J.M.: *Remembering the Destruction of Muoroto: Slum Demolitions, Land and Democratizations in Kenya*, 2011, 297,309,310p.

2.2 The Contribution of Poor Infrastructure to Chronic Poverty in Slums

Hickman (2011) distinguishes slums from formally organized and developed settlements by lack of durable housing structures, lack of sufficient living area, lack of access to safe, adequate and clean water, lack of access to humane sanitation (toilets) and lack of solid waste management systems. In slums "*flying toilets are a common phenomenon, where people help themselves in plastic bags in their houses and throw them by the way side or on top of the roof*". This scholar further argues that slums lack open legal land tenure structures because the government holds the land as its own, without a clear utility plan[43]. In understanding poverty within informal settlements, these characteristics cannot be considered in isolation as they interact in complex ways to contribute to the poverty situation commonly seen within the informal settlements. Inhabitants prefer to walk to and from work. Transport is a mere luxury for them just like taking three meals a day. They simply can't afford. The following section explains how each of the factors noted by Hickman is attributable to the endemic poverty within the informal settlements.

2.2.1: Lack of secure land tenure

Most houses are erected on illegal land. These challenges discourage property developers from setting up ideal structures since even development banks cannot approve investment loans for such unsecured plots of land[44]. Most of the residents do not even know their landlords because they use proxies to manage and collect rent without being visible. The middlemen who manage the houses pay themselves from the monthly collections which inflate the rents rates. In these areas people are evicted any time. Where evictions are resisted, hooligans simply burn down the shanties under the owners instructions[45].

There is conjectural evidence to reveal that there are frequent unauthorized forced evictions of tenants by landlords often without adherence to proper procedures due to residents' inability to pay hiked rents, or defaulting on such payments for a few months. Otiso points out the issue of arbitrary hiking of rents as a common practice in slums. Quite often, landlords use hired gangs to forcibly evict the poor tenants who oppose their hiked rent rates. In the process, the poor loose a lot of their property which is never compensated.

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[43]HICKMAN. V: *Alternative approaches to sustainable slum upgrading in Kenya: The influence of water & sanitation infrastructure improvements on stakeholder perception of well being, 2011, n.d,* 5p

[44]WERLIN. H.: *The Slums of Nairobi: Explaining Urban Misery, 2010*, 40, 43p.

[45]OTISO. K. M.: *Forced evictions in Kenyan cities, 2012*, 253-256p.

Numerous reasons are cited for evictions. Government planned projects like infrastructure (railway/ roads/ dam/ police station or school constructions) are the most common. This results in reclamation of public land on which squatters live such as road reserves, forests, riverbanks and other reserved areas. Klopp (2008) on the other hand cites 'slum evictions as a government and/or influential politician's strategies to disenfranchise political dissidents. They create animosity so as to be seen to fight and protect the inhabitants against an imminent eviction threat, and hence score political mileage over their opponents in the areas.[46] Otiso claims that frequent evictions leads to huge losses of property, time and money which worsens the impoverishment levels of the poor as indicated; *"…homelessness and the growth of new slums are partly created by evictions which causes enormous psychological and emotional trauma to parents and their children. It leads to loss of livelihood and traditional lands which accommodates essential cultural sites like grave yards and places of worship…"*[47].

To clarify this issue further, Amnesty International (2010) asserts that lack of land tenure prohibits provision of essential services like security systems, schools and infrastructure such as water and electricity; without adequate assurance from the government that their investments will not go to waste especially those who supply energy[48].

Additionally, informal settlements within Kenya are not included within the official boundaries regarded as formal by both the central government and county authorities. Such facilities are easily subjected to destruction should an eviction take place within any informal settlement as Oxfam confirms[49].

2.2.2: Temporary dwelling Structures

The nature of houses within most of the informal settlements in Nairobi and other urban towns in the country consists of tinny temporary rooms covered with polythene sheets, cartons, card board

[46]KLOPP. J. M.: *Remembering the Destruction of Muoroto: Slum Demolitions, Land and Democratization in Kenya, 2011*, 303-310p.
[47]OTISO. K. M.: *Forced evictions in Kenyan cities, 2012*, 253-256p.
[48] AMNESTY INTERNATIONAL. *Insecurity and indignity women's experiences in the slums of Nairobi, Kenya, 2010*, 31-34p.
[49]OXFAM GB.: *Urban Poverty and Vulnerability In Kenya Background analysis for the preparation of an Oxfam GB Urban Programme focused on Nairobi, 2009*, 5, 7, 41p.

or mud on the wall and the same materials or iron sheets (where inhabitants are wealthier) for roofing[50].

Owing to the inflammable state of the materials used on slum structures, congestion, diverse human activities and the unplanned manner in which most of the housing structures are build, the residents remain highly vulnerable in the event of fire disasters or other emergencies. The walk paths are quite narrow, with no access roads for fire extinguishers or piped water sources for residents. In the event of fire, landslide and/ or floods; rescue efforts are almost impossible. Whenever an emergency occurs, lost of life and property are inevitable. This was witnessed in Sinai slum fire tragedy in Nairobi which was occasioned by an explosion from a burst oil pipeline in 2012[51].

There is evidence that in some slums like Mathare and Korogosho shanties are erected near river banks, which are often swept away by rain water once the rivers flood, with others being destroyed by strong winds leaving residents homeless and incurring numerous financial and property losses. Such tragedies necessitates for those involved to reorganize their lives afresh. These situations tend to be highly destructive and they are known to impoverish many families leading to a consistent cycle of poverty. In some cases children and the elderly have been reported as the most affected people in the households[52].

2.2.3: Lack of sufficient living area in slum houses

It is common for many of the residents in informal settlements especially those within Nairobi to sub-let and lease their structures on a room-by-room basis which they then share with other members of their families or friends in order to share the cost of rent or earn some income from the house. Oxfam GB reports that in Nairobi, many households have about 6 to 7 members on average who are not in any way related to one another. In some extremely unique cases in Kibera slums, three different families share a single room, with at least five members each, leading to about 15 people sharing such a tinny space measuring about 12ft square. This makes

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[50]NDWIGA GIKIRI.: *An exploration of the effects of Male disempowerment on family unity : A case study of Nairobi south Sub location, Makadara district, unpublished masters' thesis*, 2012.

[51]OHITO. D.: *Death toll in pipeline fire tragedy in Sinai Slum now 120*. In the Standard News Paper. (Online). (Cited on Friday, the 17th February 2012). Available on http://www.standardmedia.co.ke/relationship/InsidePage.php?id=2000042661&cid=4&

[52]UNITED NATIONS DEVELOPMENT PROGRAM ENHANCED SECURITY UNIT.: *Kenya Natural Disaster Profile* , 2010, 28p.

the living conditions quite unhealthy in such units according to Amnesty International[53]. This is a significant factor that has serious repercussions on the health and wellbeing of the residents in informal settlements.

Overcrowding is an important indicator of poor housing conditions. It is inextricably tied to abject poverty since, where people are slightly financially capable, they live more decently. In slums congestion is exposes people to communicable diseases such as Tuberculosis[54].

Such overcrowding per unit combined with lack of sanitation and poor ventilation, easily leads to respiratory health complications more specifically to children. It is a known fact that poor families within informal settlements often find it difficult to cope and adjust to their normal economic situations as a result of losses of family members, especially when the bread winner dies due to illnesses such as Tuberculosis and diarrheal which are common in overcrowded living units. This is explained by Russell whose focus is on economic burden in poor countries:-

"*...... In resource-poor settings illness imposed high and regressive cost burdens on patients and their families. Direct and indirect costs of illness for malaria were less than 10% of the household income, but still significant when combined with the costs of other illnesses. The costs of treating TB, and HIV and AIDS related illnesses were catastrophic for households which took more than 10% of the income. Health service weaknesses in many countries, including low coverage, imposed user charges, and poor quality of health care, contributed to high costs in health care provision. Poor households in developing countries who have a member of the household who suffers from TB or HIV and AIDS are struggling to cope with life...*"[55]

Similarly, at the macro level, insufficient living space is a known constraint to the planning and implementation of initiatives towards increasing the number of toilets and shower blocks or other necessary infrastructure even by institutions charged with the official mandate to do so by the respective central and local government authorities because informal settlements are principally composed of highly congested housing structures.

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[53]OXFAM GB.: *Urban Poverty and Vulnerability In Kenya; Background analysis for the preparation of an Oxfam GB Urban Programme report focused on Nairobi, 2009*, 6-12p

[54]THE CANADIAN TUBERCULOSIS COMMITTEE (CTC).: *Housing conditions that serve as risk factors for tuberculosis infection and disease*. (On-line). (Cited on Friday, 17th February 2012). Available on http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/07vol33/acs-09/index-eng.php

[55]RUSSELL.S.: *The economic burden of illness for households in developing countries: a review of studies focusing on malaria, tuberculosis, and human immunodeficiency virus/acquired immunodeficiency syndrome*, *2010,* 47-155p.

2.2.4 Lack of access to improved water and sanitation

The duo lack of access to improved water and sanitation bear the same contributions in increasing the susceptibility to diseases among the poor living in informal settlements. The economic burden such infections causes on afflicted members and those who care for them is enormous. Disease conditions attributable to unclean water and environments, just like other diseases are known to reduce the capacity of individual household members and the whole community to be economically less productive if some of their members are ever sick[56]

It is common to find informal settlements adjacent to affluent localities where due to failure by the local authorities to maintain the drainage and sewerage systems, the slum becomes the dumping side for human and solid waste. Nyalenda slum in Kisumu is one such neighbourhood since all the sewage and waste from Milimani area is drained in to the slum. This is a serious challenge due to congestion of houses and high population. Furthermore, water connection within the slums are mostly done using plastic pipes that are loosely laid causing frequent bursts which makes it easy for piped water to mix with industrial and sewage effluent[57].

Sanitation in a broader sense comprises of a range of infrastructural services. Some of these includes but not limited to garbage collection, waste management and disposal, building and maintenance of drainage channels, public toilet construction and preservation, shower blocks, drainage of sewage and storage facilities[58]. Research findings highlight that the sanitation situation within informal settlements in Kenya is generally deplorable and predisposes residents to infectious and waterborne diseases[59.]

2.3: The Nature of HIV and AIDS Safety-net Initiatives in Slums

Foster (2007) defines safety nets as any form of interventions by state governments and/ or any other development agents including religious institutions and emergency aid organizations and individual philanthropists that protect people from the worst effects of social conflict and war, famine, hunger, widespread disease, low income and poverty.

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[56] Ibid, 68-74p.
[57] CENTRE ON HOUSING RIGHTS AND EVICTIONS: *Violations of women's housing rights in Kenya's slum communities, 2011*, 8-9p.
[58] IBID, 55-58p.
[59] HICKMAN.V.: *Alternative approaches to sustainable slum upgrading in Kenya: The influence of water & sanitation infrastructure improvements on stakeholder perception of well being*, 2011b, n.d , 5-11p.

The scholar further indicates that it is a short-term preventive action to shelf the poor households from hasty decisions to sell off productive assets and increase their likelihood of escaping destitution and prolonged suffering[60].

Formal state and donor led safety nets are offered in form of diverse targeted programs such as food aid, medicine, humanitarian aid, temporary shelter, water or evacuation to respond to emergency disasters for vulnerable household members. This form of support is given to enable people to regain their ability to lead to a normal life style. With regard to HIV and AIDS within informal settlements in Kenya, safety net programmes have concentrated on ARVs, nutritious food stuffs for those infected and mitigation of the effects of the disease on orphans and relatives. To ensure that people do not fall back to suffering, long-term subsequent broad-based support mechanisms like education and technical training for orphaned children and the youth, small scale investments for widows and legal protection to safeguard the rights of people against being infected at will or discrimination of the infected are introduced to empower the poor as Foster indicates.

2.3.1: Public Health Education and awareness programs

Broad based public communication initiatives have been instrumental in preventing new HIV infections in informal settlements. Scientists have enumerated the contributions of such programs as safety nets for people living with HIV and AIDS due to their precautionary nature. Among the proponents of this view is Fr¨olich and Vazquez-Alvarez (2009) who emphasise that increased public HIV and AIDS awareness has greatly contributed to the current reduction in new infections and household spending. They see these efforts as beneficial in influencing the popular behavioural change in society in Kenya. In our view communication programs have been the foundation to successful counselling initiatives in VCT centres in slums[61] as Okello-Agina[62] concurs.

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[60]FOSTER. G.: *Under the radar: Community safety nets for AIDS-affected households in sub-Saharan Africa, 2013*, 1-19p.

[61] FR¨OLICH.M - ROSALIA VAZQUEZ- ALVAREZ.R.: *HIV/AIDS Knowledge and Behaviour: Have Information Campaigns Reduced HIV Infection? The Case of Kenya, 2011*, 82-86p

[62] B. M. OKELLO-AGINA.: *Comprehensive Care for People Living with HIV/AIDS (PLHA)*. Eastern African regional workshop on AAU HIV/AID toolkit role of head of health unit care & support of PLWAs, 2010, 1-8p

2.3.2: Financial support and Cash transfers

International development organizations have been involved in financial and social support activities in slums in Kenya. Notably among them are Oxfam GB and USAID that have funded several HIV and AIDS projects in partnership with local NGOs and CBOs as well as the government. For the first time in 2010 the government introduced cash transfer programs to assist people living with HIV and AIDS (PLWHAs) and the elderly in society to use on their basic social needs. Other beneficiaries of the programme are those who are totally orphaned and vulnerable children (OVC) due to HIV and AIDS, the unemployed people who take care of orphans in their households, non-pensionable elderly persons who bear the burden of responsibility for many orphans due to HIV and AIDS deaths. Such cash transfers then can be utilized in education of orphans and supporting the general livelihoods of the beneficiaries[63].

2.3.3: Income Generating Activities (IGAs) and Livelihood support programs

Owing to the unpredictable nature of continuous funding for HIV and AIDS initiatives, especially now that the donor community has withheld financial support, some NGOs who are working independently or in partnership with the government have sought to implement income generating activities and other livelihood programs for PLWHAs. Such programs are mostly financed through registered groups of PLWHAs. They include for example Micro Financing activities that bring together PLWHAs which offers therapeutic effects to the members, Voluntary Savings and Loaning (VSL) for small businesses, Children Development Accounts (CDAs), and special skills training combined with entrepreneurship with linkages to micro financing opportunities for group members[64].

2.3.4: Human Rights and Legal protection

Kiragu (2012) explains that since the wider recognition of HIV and AIDS as a serious developmental concern in Kenya, legal protection for people not to be infected at will and basic rights of the PLWHAs began to be addressed. Advocacy for rights of PLWHAs and discrimination at the workplace, schools and public places have been on-going. Unfortunately protection within the household is rarely addressed. Different stakeholders have concentrated on

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[63] JAMES-WILSON.D et al.: *Economic Strengthening for Vulnerable Children Principles of Program Design and Technical Recommendations for Effective Field Interventions, 2011*, 38p.

[64] JAMES-WILSON.D et al.: *Economic Strengthening for Vulnerable Children Principles of Program Design and Technical Recommendations for Effective Field Interventions, 2012*, 5-6p

diverse activities. Some of these include free access to Anti Retroviral treatment for all the infected people, improved healthcare services for expectant mothers, asset protection for single parents after their spouse's death, Social support for PLWHAs by state agencies as well as advocacy against different kinds of discrimination in places of worship, colleges, in relationships and public service delivery points especially for women and girls[65].

2.4 Emergency support Systems

The PLWHAs in slums have been assisted through emergency support initiatives in the past. These initiatives are organized in form of rapid humanitarian assistance for those affected by tragedies like fire, floods or social strive due to ethnic differences. The 2007/2008 post election violence in Kenya for example saw many of the PLWHAs lack medical supplies and food stuffs due to general breakdown of delivery systems as a result of insecurity and fighting in Kibera and Mathare slums in Nairobi. Similar cases were witnessed in Nyalenda and Bangladesh in Kisumu and Mombasa respectively. Emergency Support Services (ESS) mainly by the Red Cross Society and other stakeholders provides what is basically required depending on the situation at hand. In cases of fire, temporary makeshifts, blankets, food, water, sanitation and medical care are some of the essentials provided depending on the agencies capacity. Security to safeguard women and girls against sexual violence and rooting of property are some of the immediate activities that are initiated[66].

2.4.1: The General Perception on the Poor Living with HIV and AIDS

The PLWHAs are perceived differently in informal settlements.

a) Rejection and stigmatization: Depending on the diverse and unique socio-economic mechanisms adopted within each informal settlement, it is reported that those who are publicly known to be living with HIV and AIDS often face quiet rejection and stigmatization as a result of their Sero-positive status (although people pretend that they genuinely accept them fully). This then greatly affects how they go about with their daily life chores and social interactions since they are aware that people are thinking about them, and there are those that look at them differently as one of them claims.

[65] KIRAGU. J. W.: *Leadership challenges in strengthening national legal instruments and frameworks to address the consequences of HIV/AIDS from a gender perspective, 2013,* 19-28p
[66] See Kiragu, 24p

"*…. For me such stigma affects how I'm able to live as a single widowed mother of three. For example, my main source of income is running a small business of selling sukuma wiki [kale] at the local market here. But since most people in this area know my status, they openly claim that they cannot buy greens from me. They say, if I cut myself and breed on the on the greens, they will definitely get AIDS…The stories are more than just that*[67]*. These things make me feel so bad about myself".*

b) Fear of disclosure: Some of the possible negative repercussions residents within in settlements often have to grapple with because of declaring their HIV status is to wish they never told the public. Psychologically the person thinks that people are looking and thinking about him/ her. Some people who have declared their status therefore keep it to themselves, in fear of isolation and neglect. The situation is more complicated for those infected with HIV because it is a requirement that they must disclose their status in order to access treatment (ARVs) as well as other support services such as food, bursaries and scholarships for their children as one lady explains.

"*….They even tell their children not to play with my children…, they abuse my children and tell them their mother is sick, she is just about to die any time. I have seen it happen to other people. The people who are HIV positive are not accepted in the society here. However, I cannot hide my health status, because I need assistance for my children and I*[68].

c) Violence: Unge, et al (2008) reports that some of those infected with HIV have also reported to be subjected to ridicule and mockery. Some have endured violent encounters from their partners (especially women) when there is evidence that it is the male partner who infected them with the HIV virus. Arguments on marital infidelity in this context often turn violent as Men attempt to silence the women not to talk about their immoral behaviour[69].

Other women have been victims of violence from family members who wanted to prevent them from inheriting their family property after the death of their husbands. This is particularly common where marital unions were not qualified as official either through payment of dowry or by legal means and where directional documents such as wills or verbal declarations by the deceased about ownership and control of family property after their death should be huddled. If

[67] INTERNATIONAL MONETARY FUND.: *Kenya: Poverty Reduction Strategy Paper, 2010*, 61p

[68]UNGE et al.: *Reasons for unsatisfactory acceptance of antiretroviral treatment in the urban Kibera slum, Kenya, 2011*, p3-6

[69] See Unge, p4

attempts to disinherit them fail, some women reported to being threatened or being excluded by family and thus living in fear[70].

d) Social Ostracism: Some of the PLWHAs have also indicated that they consequently received little support if their illness was deemed by their relatives or community members to be a form of punishment for something they did or did not do to the departed. When perceived in this way, those affected by HIV and AIDS are treated with harsh judgmental sentiments. One such group of persons reported to be highly susceptible to be subjected to social ostracism are orphaned children whose mothers were commercial sex workers. According to Njoroge et al (2010) such children tend to be at a greater risk of being neglected because they are considered a curse for their parent's immoral behaviour. They are presumed to be products of an evil enterprise[71].

e) Acceptance, support and encouragement: whereas most of the reported perceptions towards those affected by HIV and AIDS mostly tend to bear negative perceptions, there are quite a number of people in society who are empathetic, friendly, and supportive. Among them, social counsellors, community health workers, neighbours, the religious and medical staff are mentioned. Some churches are applauded for their involvement in home based care such as the small Christian communities in the Catholic Church among others, as Njoroge highlights.

2.4.3: The Role of Engendered Poverty in Slums

Gender related poverty in slums has attracted immense scientist's attention. Some of the prominent engendered poverty issues include:-

a) Existence of intergenerational poverty and sexual relationships

The nature of cross generational, intra-generational and intergenerational gender poverty in slums has been an issue of great interest for researchers. Gender relationships determine the way resources are shared and controlled between males and females in a diverse ethnic set up in slums. Likewise there is high level of cross cultural intermarriages where customary laws of the spouses are different[72]. Most adolescents and older women, some of those who are married indulge in different forms of commercial sex to earn a living. Transactional sexual prostitution between young people and older generation, often sustained by need to trade sexual favors for

[70] Unge. P5

[71] NJOROGE et al.: *Female sex workers, FSWs, AIDS orphans multi prolonged problem in Kenya: A case study, 2010*, XII p

[72] KABIRU et al.: *Transition into first sex among adolescents in slum and non-slum communities in Nairobi, Kenya, 2010*, 453p

economic gain are some of the ways in which HIV and AIDS continue to be transmitted. Furthermore, early sexual debut for adolescents within informal settlements remains an important concern to policy makers and health workers as Amuyunzu-Nyamongo and Magadi had established that the mean age for sexual debut among adolescents in informal settlements is between 9-10 years for girls and 12-13 for boys which is significantly lower compared to the national average which stands at 16 years for boys and 14 for girls[73].

b) Multi-generational sexual relationships in Slums

It has emerged that despite the high awareness levels and increased knowledge on the ways through which HIV and AIDS are transmitted and could be prevented, certain population groups such as adolescent boys and girls and married couples continue to indulge in high-risk sexual behaviour. People are developing a 'I do not care attitude'. The important characteristics of multi-sexual partnerships and social and economic factors that sustain their existence among residents in slums reflect a worrying trend. The older men are known to seek unprotected sex with adolescents believing that they are not infected with HIV or AIDS due to their tender age. Further still, older wealthy women were found to seek for young men as their security and business advisors and pay them in-kind though sex and pocket money. Some pay back by educating the boys and exposing them to high class life styles (driving posh cars, holidays abroad)[74]. In our view all these practices are driven by poverty and greed.

c) Sexual and physical assault in Relationships

As Erulkar and Matheka reports, there are generalized incidences of physical assault as well as sexual violence (rape) towards women in most of the informal settlements, which is quite often never reported. This can be attributed to the general lack of adequate policing in slum areas by government security personnel together with the attitude that slums are insecure and crime is an acceptable norm, since it is inevitable. Others blame unemployment among the youth, government absence for the high rate of criminal activities. To an extent, crime is a normalized

[73]AMUYUNZU-NYAMONGO, M. K & MAGADI, M. A.: *Sexual privacy and early sexual debut in Nairobi informal settlements, 2009*, 143-158p
[74] NATIONAL AIDS CONTROL COUNCIL (NACC).:.*Kenya National AIDS strategic plan 2009/10 – 2012/13 (KNASP III). Chapter 2,* 5-13p.

way of life. Youths steal, rape, murder and life goes on as usual even if they are known[75]. Whenever people report such cases to the police, they face imminent attack in retaliation. Some of them have had their houses burned or young daughters raped in revenge.

d) Gender power differences and Resource Manipulation

As a result of gender power differentials among men and women in Kenya, Erulkar and Matheka point out that there are significant socio-cultural norms and practices that are known to influence the nature of social and sexual relationships. Such issues include the positions of young people involved in sexual relations with older partners (both female and males) together with the position of women, which are thought to be inferior to those of men. There is conjectural evidence to the effect that such groups have limited informed channels of decision making on sexual relationships. They lack ability to negotiate for or practice safe sex and informed choices to safely use contraceptives even in situations where their survival depends on transactional commercial sex trade[76]. Some methods of safe sex like use of a condom never work in slums. Unprotected sex therefore puts most sexually active people at risk of contracting HIV and /or transmitting it to their partners.

e) Social vulnerability and Low economic Opportunities

Generally, most of the slum residents have fewer economic opportunities and lack permanent sources of income. The nature of casual employment in construction sides, industries and hand to mouth businesses serve as temporary means of subsistence. The concept of long-term investment and savings for future use are unimaginable. Structural challenges to secure credit facilities such as loans, overdrafts, mortgages and other instruments from the commercial financial institutions require guarantors, reference notes, credible credit history and collateral (land title deeds) which slum residents cannot get since they live in illegal land[77].

There are newer strategies over the recent past that seem to address this challenge through innovative financing approaches such as organized voluntary savings and loaning programs (VSLP), Group Based Micro Financing (GBMF), Technical Skills Training (TST), Revolving Funds Schemes (RFSs), the youth and women enterprise funds which are government sponsored. These facilities accord borrowers' flexible borrowing terms and other approaches

[75]ERULKAR.A.S- MATHEKA. J.K.: *Adolescence in the Kibera Slums of Nairobi, Kenya, 2012*, 14-15p
[76] ERULKAR.S.A-MATHEKA.J.K.: *Adolescence in the Kibera Slums of Nairobi, Kenya, 2012*, 14-26p
[77] D. M. MUVENGI.: *Poverty, church, and development in Kenya: A case study of Kibera slums in Nairobi, 2011,* 34-36p

such as expanding market opportunities for different products produced through different HIV and AIDS livelihood support initiatives (LSIs). Some of investment examples include groceries Kiosks, used cloth stalls, food stores, shoes, curios and hand basket shops and M-pesa outlets. Micro-Finance service institutions have grown rapidly in micro banking facilities. They include K-Rep bank, Faulu Bank, Women Trust Bank and Waumini bank which were SACCOs before they were upgraded in to banks[78].

As a critical concern of engendered poverty, women in slums have consistently scored poorly in education and technical skills attainment compared to men. This scenario is visible in the job market and senior leadership positions. Men are usually the majority in almost all the sectors in the labour market and the political arena[79]. Girls for example are most likely to get married at an early age or be predisposed to early unwanted pregnancies not withstanding HIV and AIDS which increase the cyclical family poverty for the female gender[80].

2.5: Policy Framework on Poverty and HIV and AIDS in Kenya

A set of policies have been established and are in use at different levels of application on both Poverty reduction and HIV and AIDS management in the Country.

2.5.1: Policy Framework on HIV and AIDS

The legal framework on HIV and AIDS mitigation in Kenya can be traced back to *Sessional Paper No. 4 of 1997 on AIDS in Kenya* which was the first legal policy document on HIV and AIDS by the government of Kenya. This was following an exponential increment in the number of deaths attributable to the disease since the first cases of HIV infection were reported in the country in 1984. It took a period of 13 years between the first reported AIDS case and the enactment of an official policy by the government. This long period shows extreme laxity by the government of the day to address issues concerning HIV and AIDS[81].

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[78]JAMES-WILSON. D et al.: *Economic Strengthening for Vulnerable Children Principles of Program Design and Technical Recommendations for Effective Field Interventions, 2011*, 5-6p

[79] D. M. MUVENGI.: *Poverty, church, and development in Kenya: A case study of Kibera slums in Nairobi, 2011,* 34-36p

[80]ERULKAR. A. S and MATHEKA. J. K.: *Adolescence in the Kibera Slums of Nairobi, Kenya, 2013*, 18-19p

[81] KIRAGU.J.W.: *Leadership challenges in strengthening national legal instruments and frameworks, 2010,* 19-25p

After persistent advocacy campaigns by NGOs and civil society, the sessional paper proposed the following aspects:-

1. The formation of a National AIDS Council to enhance and spearhead HIV prevention initiatives
2. The National AIDS Council would formulate polices to address HIV and AIDS issues as they were emerging
3. The need for establishing a functional institutional framework for facilitating a diverse (multi-sectoral) AIDS control programme
4. The need for increasing the capacity of institutions dealing with issues relating to HIV and AIDS and coordinating their work to ensure efficiency
5. The need for enhancing the existing leadership; resource mobilization for AIDS control was pointed as a focal area together with the need for inclusive care of people affected by HIV and AIDS; and
6. The need for proper coordination of all pertinent actors including government departments, NGOs, community-based organizations, religious organizations, the private sector and donors, among other non-state actors

In 1999, the then president of the republic, Daniel Moi declared HIV and AIDS a national disaster. Consequently this move led to the introduction of HIV and AIDS education from lower levels and in all learning institution by the year 2000. At this time, the government did not have express laws or statutes to address HIV and AIDS related issues.

The Sessional paper developed in 1997 on HIV and AIDS in Kenya however provided shallow guidance on how to address some issues as pointed out by Kiragu in his first report in 2000 and 2010a. Some of the issues that were lacking included; respect of human rights and criminalization of any form of discrimination towards HIV positive and those living with AIDS, testing for HIV and informed consent of clients, right to counselling prior to testing, concerns on the confidentiality of individual's HIV statuses, medical and research ethics related to HIV and AIDS, criminal sanctions against individuals who deliberately infected others as well as religious and cultural application of legislation that would be enacted in regard to HIV and AIDS matters[82].

[82] See Kiragu, 22p

Between 2000 and 2005, the National AIDS Control Council developed and implemented the first Kenya National HIV and AIDS Strategic Plan (KNASP) 2005/6. This strategic plan was used as a tool to increase stakeholder participation and implementation of the envisioned multi-sector approach that targeted five priority concerns namely; prevention and advocacy, treatment, continuum of care and support, mitigation of the socio-economic impact, monitoring, evaluation, and research together with management and coordination strategies[83].

During the same period, the directorate of personnel management developed a comprehensive public sector workplace policy on HIV and AIDS which formed the basis for the rapid scaling of similar work place policies in other working environments in the private sector. Some of the statutes informing the implementation of Public Sector workplace policy included, the revised Service Commissions Act Cap 185 which provides for non discrimination and improper procedural dismissal from duty in case of ill health as a result of the disease[84].

The Employment Act Cap. 226 which provides for non discrimination of employees, sets the minimum working conditions for employees leaving with the disease. The factories and other places of work Act Cap. 514 set a provision which addresses the health and welfare issues of persons in their work place. The HIV and AIDS Prevention and Control Bill which was gazetted in 2004 has instrumental provisions on voluntary HIV testing, non discrimination of those infected by HIV as well as non disclosure and confidentiality by health workers who know the statuses of their clientele. It guides the way employers and social counsellors should conduct their relationship with those infected by HIV and/ or AIDS[85].

Following the implementation of the first strategic plan, a second one, The Kenya National HIV and AIDS Strategic Plan (KNASP) 2009/10 was developed and implemented. The issues of concern featured in the second KNASP included the need to; reduce the spread of HIV, improve the quality of life of those infected and affected, and mitigate the socio-economic impact of the epidemic on society. It further targeted prevention of new infections, need for

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[83] NATIONAL AIDS CONTROL COUNCIL (NACC) .: *National HIV/AIDS monitoring and evaluation framework, 2012a*, 2-4p

[84] DIRECTORATE OF PERSONNEL MANAGEMENT.: *Public sector workplace policy on HIV and AIDS, 2011*, 15-18p

[85] Ibid, 17p

improving the Quality of Life and the mitigation of socio-economic impact[86]**.** Furthermore, The HIV Prevention and Control Act, 2006 had been passed and became operational in the year 2009. This law was an important step in strengthening the human rights framework which is necessary to support universal access to services in relation to HIV and AIDS initiatives.

Currently, there are additional policy guidelines in place pertaining to home based care and the breastfeeding of children born to HIV positive mothers, Voluntary medical male circumcision (VMMC) and in the prevention of mother to child infections (PMCT).

The Kenya National Aids strategic plan 2009/10 – 2012/13, which is integrated within the macro frameworks of vision 2030, has been implementing a number of policies namely; the first Medium Term Plan (MTP), 2008-2012, The health related millennium development goals (MDGs), different Sector frameworks for HIV and AIDS. The new Kenyan constitution (2010) and various international instruments on Human rights provides the key guidelines for the implementation of HIV and AIDS interventional activities by different stakeholders in the country.

Most importantly, the implementation of the Kenya National Aids strategic plan 2009/10 – 2012/13 has clear considerations on strategic partnerships with important developmental partners who are keen on supporting HIV and AIDS initiatives[87].

In our view a number of HIV and AIDS related policies are still missing such as those to regulate:-

- Matrimonial contracts between HIV positive and negative couples especially those who are planning to marry or where one might die of the disease
- How to deal with people imposing as HIV and AIDS suffers to attract sympathy and social support from the government, donors and the civil society
- Policy on how to deal with those who are seeking to get infected at will, so that they may enrol in social support programmes

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[86] NATIONAL AIDS CONTROL COUNCIL (NACC) .: *National HIV and AIDS monitoring and evaluation framework, 2011b,* 2-8p

[87] NATIONAL AIDS CONTROL COUNCIL (NACC) .: *Kenya National AIDS Strategic Plan 2009/10 – 2012/13 (KNASP III),* 15-17p

- Property management and inheritance after death of parents/ unmarried young men/ girls as a result of HIV and AIDS who had no children to inherit their property.
- Corruption issues related to HIV and AIDS drugs and programmes that misuse donor funds purporting to target PLWHAs especially innocent orphaned children in society
- People who accuse others of infecting them while they had the virus prior to their sexual encounter in order to distort money from them
- Religious pastors/ leaders who claim to cure HIV and AIDS through prayer/ anointing/ cleansing to distort money from their unsuspecting followers by telling them to plant a seed of a certain amount to be healed for example the Pastor George Kanyari as exposed by Jicho Pevu in November 2014.
- Herbalists or conventional medical staff who lie that they can cure HIV and AIDS to get money from unsuspecting PLWHAs
- Electronic texting (Short Messages) and other application of the media to discriminate or unwillingly expose people's status.

2.5.2: Policy Framework on Poverty Eradication in Kenya

The macro frameworks on which poverty eradication policies in Kenya are founded began with the introduction of Sessional paper no. 10 of 1965 on '*African socialism and its application to Kenya*'. This mega pursuit of social change had the desire to combat what was perceived at the time, as the three major enemies of human development, which were namely: - ignorance, disease and poverty. However, five decades from 1970s through 2010 poverty has not been rapidly addressed as it was envisaged in the subsequent session papers. Since 1960s, many efforts have been made with other policy guidelines being enacted and implemented which include:-

1. The Copenhagen declaration of 1995 on combating extreme poverty otherwise referred to as "The World summit for social Development (WSSD)".

2. The eight Millennium Development Goals (MDGs) following the United Nations Millennium Summit of 2000,

3. The Monterrey Consensus after the United Nations International Conference on Financing Development of 2002 where the united nation member countries renewed their

commitment to increasing their ration on financing development programmes in poor countries,

Besides these commitments, the government of Kenya has introduced and enacted other policy guidelines to spearhead the countries poverty eradication programs. These include:-

1. The National Poverty Eradication Plan (NPEP) 1999 – 2015. This is a long term plan which outlines broader action-plans and measures by the government of Kenya aimed at reducing extreme poverty and hunger in the country by half by the year 2015 in line with the MDGs target[88].
2. Vision 2030 and its first medium-term plan (MTP) – 2008 - 2012. This is a development blue print aimed at transforming Kenya into a modern, globally competitive middle income country with a high quality of life for all citizens by the year 2030[89].
3. The medium term framework (contained in the Economic Recovery Strategy for Wealth and Employment Creation (ERSWEC) 2003 - 2007). This is a strategy that spells out the priority policies needed by the government of Kenya to revive the economy. Its implementation was tied to the nations resource pool through the Medium Term Expenditure Framework (MTEF)[90]
4. The Poverty Reduction Strategy Paper (PRSP) 2001 - 2004. The PRSP most important objective was to stimulate fast economic growth and reduce poverty so that the nation is at par with its positioning at independence[91]. Despite all these guidelines the Kenyan population continues to be affected by the endemic poverty at 49% (CBS, 2012), with some counties poverty rate being over 63%

In our view although these guidelines played an important role in the fight against poverty in the country, none of them targeted the poverty is slums. Further there is need for more proactive strategies to address aspects that reduce the gains in this front like HIV and AIDS, manmade and natural disasters alongside the war on extreme corruption in both National and county governments. Although, Retributive strategies of wealth through devolution in the New

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[88] WAITHAKA, J.K-FRANCIS ANYONA.F-AGNES KOORI.A.: *Ageing and poverty in Kenya country report for the regional workshop on ageing and poverty in sub-Saharan Africa*. *On 29th – 31st October 2003 in Dar es salaam Tanzania,* 2-5p

[89] MINISTRY OF STATE FOR PLANNING, NATIONAL DEVELOPMENT AND VISION 2030 (GOK).: *Vision 2030, First Medium Term Plan, 2008 – 2012*, 1-15p

[90]See Ministry of state for National planning, 2008, 3p

[91] Ministry of state, 4p

Constitution 2010 seems to have taken effect with the establishment of county systems, there is a lot of infighting between governors, senators, county assembly members and the public. It is important to consistently addressing land issues and subsidising the cost of education and technical training, creating employment opportunities under the self employment initiative in county governments and developing infrastructural facilities to attract external investment may reduce poverty in future to 30 per cent margin and below.

2.5.3 The Fight against HIV and AIDS in the Advent of Poverty

According to the National AIDS Co-ordination Council (NACC, 2010) and National AIDS and sexually transmitted Infections (STI) Control Programme (NASCOP, 2011) since the first AIDS case was reported in Kenya, over 3.6 million Kenyans aged between 15 and 49, and over 600,000 children have died of the disease. By 1999 it was estimated that 7.5% of the adult population and about 55,000 children under the age of five were infected with HIV (NASCOP, 2000). Although by mid 2001 only 105,647 AIDS cases had been reported, high number of cases were not reported owing to the social stigma associated with the scourge at that time (CIDA, 2008, and Daswani, 2008). Early 2007, 1.9 million Kenyans (about 9% of the adult Population) were estimated to be living with the disease, majority of whom were in urban areas. However HIV prevalence fell from 7.2 in 2007 to 5.6% in 2014 and the incidence from 0.7 t0 0.4% in 2014 (Journal of Acquired Immune Deficiency Syndromes, 17th February 2014)

The main questions in this study then are; what kind of poverty is related to HIV and AIDS? What is the relationship between the HIV and AIDS epidemic and poverty in the study areas? Does poverty incidence increase or reduce as the epidemic increases or vice versa? What is the link between the two? Are there existing preventive measures on both challenges at the same time? If yes, how is their performance? If no what should be done? Do they serve the intended purpose? Are there policy guidelines on how to enhance the coping and survival tricks of the poor? If they are there, how is their performance? If there is no relevant policy, what could be done?

2.5.4 Distinction between HIV and AIDS related poverty and poverty as a result of other conventional causes

In this section we strive to respond to the question; what is the distinction between the HIV and AIDS related poverty and poverty caused by other conventional factors? This is a crucial framework in understanding how he poor are affected by the AIDS scourge. Poverty is a complex issue. The way poverty is conceived determines how it is measured. In this study we define poverty as a state of deprivation and inequality. Most definitions associate it with a "*lack*", "*deficiency*" and/ or "*inability*" to attain certain necessities required for human survival and social welfare. Poverty may amount to denial of opportunities to graduate out of undesirable condition of need and suffering. More often, it is understood to constitute inability to purchase a minimum bundle of basic goods and services to satisfy a set of human needs. There is also the conventional view that perceives poverty in terms of income and consumption.

Nevertheless there is no consensus on what human needs are and how they can be universally identified and measured. (See Warren, 2008:112 and Ndolo (2004:9). It is important to acknowledge that needs of an individual change constantly with time, preference, income level, social status, comparative perceptions, gender, environment and age among others.

2.5.5 Framework to Determine HIV and AIDS Related Poverty

This section presents a framework for analysing the nature of poverty that could be associated with the HIV and AIDS pandemic based on the absolute, relative and the people's perception on poverty measurements. When poverty is defined in *absolute terms*, needs are assumed to be fixed at a level which provides for subsistence, basic household equipment and expenditure on essential services. Minimal needs are set at an abject level under which human survival is apparently threatened by hunger, illiteracy, poor sanitation, lack of shelter, inability to access minimum education, lack of safe drinking water and health care services. Incidentally, it neither describes the extent of poverty nor income inequality levels within the society or the fact that needs are socially determined and they vary and change over time. It is adjusted periodically to incorporate advancement in technology, improvement in national income levels and standards of living (Warren, 2011a:134).

Relative poverty line reflects a subjective variance in poverty incidence. It is more flexible and it allows for the minimum needs to be revised and adjusted according to the changing realities in society over time. It holds the view that people are relatively deprived if they cannot obtain those

desirable basic conditions such as diet, amenities, preferably acceptable standards of living and amicable social services. This implies that poverty imposes withdrawal or exclusion of the poor from active membership of society since they cannot engage at the same level with others. This type of poverty leads to socio-economic discrimination from productive assets like education, capital, meaningful sources of income like employment, investment opportunities creating visible deprivation, inequality and marginalization of the have-nots in society. *People's perception on poverty* seeks to generate actual analysis based on peoples' definition of their real life situations and tribulations. It assumes that people can explain their life experiences more accurately than an observer. It examines the actual sources of household income, expenditure on essential attributes with which human survival would be threatened such as food, rent, education, health care, water, energy, clothing and transport. The bundle of basic commodities varies from one region or country to another (Howard, 2011:64-68)

2.5.6: Categories of the Poor who are affected by HIV and AIDS

To determine those who were poor before AIDS and how they have been affected by the pandemic, and the other emerging types of the poor as a result of the disease, a framework of analysis have been established for the purposes of this study. The advent of AIDS in our view seems to produce five (5) categories of the poor, namely:-

i) **The chronic Poor:-** Those who were chronically poor even before the advent of HIV and AIDS in 1980s. This poverty could have been caused by lack of productive assets like land, livestock, investments, employment or inappropriate distribution of resources. These people lack financial capital, awareness, technical skills and motivation to intervene in transforming their lives. They rely almost entirely on the natural environment (rains, food crops and livestock farming, wild-vegetation and fruits gathered from the bushes) for their survival. They are victims of unfavourable resource distribution, adjustment policies and bad political regimes. HIV and AIDS to this group make life disastrous and pathetic. They are unable to survive unassisted by NGOs and social welfare agencies or the state or country government.

ii) **The conventional Poor:** These are members of the society who were not originally considered extremely poor even before the advent of HIV and AIDS. Household members are victims of illiteracy, landlessness, unemployment to an extent where they cannot provide fully for the basic needs. Loss of a family member due to

AIDS, illness of a bread winner or a member of the family makes the family extremely vulnerable. Children drop out school/ college and family assets like land, real estates and livestock are sold to meet basic needs like food, health care and education, which makes the family desperately needy and deserving. They live in a state of cyclical situation, where poverty breeds poverty. Children inherit poverty from parents because they lack means of breaking the poverty chain like education and permanent sources of income. This type of poverty is multi-generational. It is passed from one generation to the next.

iii) **The New Poor:** These are the direct victims of HIV and AIDS. They include those who have fallen below the poverty line as a result of AIDS related deaths of household members, particularly bread winners. Orphans some of whom are on ARVs and nutritional support programmes. For some of them poverty makes them become hardcore poor. Others are on transitory especially those on scholarships and social welfare support from the church programmes like Mary Immaculate Health Clinic (MIHC) Mater hospital, Mukuru promotion centre and local NGOs. Some of them were wealthy and stable before they were affected by HIV and AIDS.

iv) **The Vulnerable groups:** These are households who may be described as the 'bolder line poor'. They are usually on the brink of the poverty line. Their parents may be in well paying jobs but they risk dying of AIDS since they are HIV positive and are being sustained by ARVs. Any slight shock like prolonged illness, hospitalization or death of any one of them leads the household members to new poor who are struggling to survive through risky practices like prostitution that may lead to spread of HIV to other members of society, although initially they were financially and socially stable.

v) **The Detrimental poor:** These are hang-on-poor individuals and households. They were extremely poor and their situation has worsened after members have died of AIDS. They have never being poverty free before or during the advent of the scourge. Economic instability, tribal clashes of 1997/1989 made them worse off. They require other types of empowerment like technical skills, capital for investment alongside ARVs and relief assistance. All these groups are lambed together as poor people with unclear targeting procedures to identify and target them for social support.

2.6: Targeting Framework for beneficiaries in Slum Intervention Programmes

Targeting is a process used to identify those who ought to benefit and exclude those who should not benefit from a safety-net initiative. It is based on the fact that due to limited resources, some individuals or groups (who are not extremely needy) have to be excluded from receiving benefits of a support programme. Targeting therefore denotes delivering recourses to those who need them most. Choices of the target group and the delivery procedure are essential mechanisms of reaching the needy. Judging the success or failure of targeting is different from assessing the impact of the whole programme. However a poorly targeted programme will have high chances of failure. If resources are readily available, a Cost Benefit Analysis (CBA) would have to be conducted parallel to targeting criteria to ensure accuracy. The main variables for analysis constitutes of a critical determination of the direct and indirect beneficiaries that programme reaches, the extent and implication of the targeting errors that might emerge and who were included as targets to benefit is clearly visible. To determine whether a programme is reaching direct, indirect or non beneficiaries, the following criteria could be applied:-

a) Direct Beneficiaries: Entails those who enjoy the first benefits of a development initiative. For instance a small scale fish shop owned by five HIV positive people benefits the group members first if profits were to be shared. Indirect beneficiaries however would constitute those who benefit from the project in other ways like getting fish near their neighbourhood, family members whose needs are settled with a proportion of the money the members gain as their individual shares and the fish mongers who supply the fish. The next of kin who eat the fish fall under this category.

b) Non-beneficiaries*:* Never gain anything from the fish shop either in terms of services, products or cash; in which case the existence of the shop never influences their lives at all. Tarmac of a rural road may benefit those who own cars first, although the poor casual workers who build it may earn some income from the work. Both of these are direct benefactors. However, commuters who get to their destinations faster and investors whose businesses improve as a result of this road are indirect beneficiaries. In this study this approach is used to determine how people who are infected and/or affected by HIV and AIDS are targeted and the nature of targeting errors that emerge when the targeting method missed them.

2.6.1 Categories of Targeting Errors in Intervention Programmes

A targeting error is a parameter or yardstick to measure to what extent a development project or programme has missed those who need its benefits most. Here we used this framework to measure whether projects targeting the effects of HIV and AIDS help those who deserve their mitigation more than the others. This is a criterion for assessing the development initiatives that benefit none deserving members of the society either in total or partially. An error can be positive or negative depending on its position on the scale. According to Murray (2009) two errors of targeting are common; E-error where benefits reach people who do not need them most (non-poor), and therefore not among those who were initially targeted in a safety-net programme.

An F-error arises where a project fails to reach the targeted beneficiaries due to inadequate resources or poor management style. A range of percentage intervals are used to determine the degree of targeting errors as follows:- *0 – 25 = very low*; this occurs where the project raises very low targeting errors, implying that it reached most deserving and needy people. This implies that the project reaches less non-poor people and therefore well targeted. *26 – 50 = Low to medium*; meaning that the impact of the project reaches at least half of its target. *50 – 75 = relatively high*; shows that the project misses between a half and three quarters of its target. Then, 76+ = *High*; targeting error are where the proceeds of a project go to less than a quarter (a small proportion of those it was intended to help).

Any project that misses the target by half (50 - 75) and above should actually not have been allowed, since it is a total waste of resources that go to the non-deserving members of society.

2.7: Theoretical Framework

2.7.1: The Social Exclusion Theory

Social exclusion as a concept and theory is relatively new. Initial debates on the concept are associated with the work of Rene’ Lenoir (1974). Nevertheless more than two centuries earlier, Adam Smith (1776) in his famous classical work on ‘*The wealth of Nations’* had extensively discussed social deprivation of the minority individuals and groups’ without directly analyzing the term. Amartya Sen (2000) in his work on “*Social Exclusion: Concept, Application and Scrutiny*” brought a new dimension on the causes, types and implications of this practice in

society. He affirmed that any form of discrimination that alienates a proportion of society on whatever basis amounts to social exclusion.

According to Barry and Le Grand (2002), Sherpley (2005), Lynn Todman (2006), social exclusion refers to processes in which individuals and entire communities of people are systematically blocked from accessing their rights, opportunities and resources such as land, housing, employment, income, healthcare, transport, water, education, security and civil engagement on the basis of politics, religion, social status, geographical locality, ethnicity or other social factors. Adolfo Figueroa (2006:124-129) develops a new theoretical approach, which focuses on social inequality and introduces the concept of social exclusion into the analysis. In so doing, he specially addresses the question: is inequality a result of some peculiar form of social integration, or rather an emerging form of discrimination taking place in the social process of development? Social inequality is conceived in this study in broader concerns than income, property and rank/ social status inequalities.

At any given point in time, Adolfo (ibid, 126p) argues that individuals are endowed with different amounts of valuable assets. Economic inequality is the differentiation in ownership of productive assets, whilst social inequality is a combination of inequality in social status, authority and power, political and cultural assets. A society where the only source of inequality is economic assets could be called a "liberal society" as Adolfo claims. Political and cultural assets would be evenly distributed. In this society, "the only difference between the rich and the poor is that the rich have more financial resources and property". Adolfo's analysis goes further to assert that *Exclusion from the political process*, in the context of democratic involvement and participation, meaning; exclusion from citizenship and individual patriotism rights.

Democratic capitalism functions with a system of rights which, amongst other things, acts to set limits to the inequalities generated by the market system and income differentiation, and thus makes society equitably aliened. The factors which determine the set of rights in a particular capitalist democracy on the demand side may include: social pressure, tolerance to inequality, the culture of inequality, degree of democracy, and level of income amongst the poor as determined by their perennial sources; and on the supply side: the production capacity of the economy, the preference of the ruling classes to allocate scarce resources to the production of rights in the form of public goods, and international agreements. In the short run as Adolf observes, the state policy to manage aggregate demand is the most important variable which

explains the changes in the effective delivery of a given set of rights. Periods of economic growth (even in the short-time, like when farmers get high yields in a certain cash crop) will be favorable and periods of recession (prolonged drought or lack of market for a certain product) become unfavorable. All citizen rights are not universal, and even universal rights are not equally realized in society. These insights are partly adopted from (www.wikipedia.org accessed, 18/10/2014) and (www.aunt.sue.info accessed, 19/10/2014)

2.7.2: Rights: As an exclusion factor

When rights are non-universal, or when formally universal rights are not effective in practice, some people are excluded from some of their benefits or the rights themselves: participation in the administration of political power (the right to elect and be elected), the right to ownership of property, to justice, to social protection, and to basic services like education, healthcare, an income or information. Where people are deprived of an essential basic right, then social exclusion is evident as reflected in: - (www.adb.org/document, www.radical.org.uk and www.rrojasdatabank.info) accessed, 20/11/2014 at 10.45pm.

In our view this theory is relevant for this study since inhabitants of slum settlements are first geographically and socially alienated. Secondly, they are isolated from basic services such as ideal sanitation (posing serious health risks), habitable housing, safe drinking water, affordable electricity, social amenities, nutritious food, security, good infrastructure and permanent sources of income. These aspects reduce people in slum areas to minorities compared to those from the middle and upper class, who live in areas with better social amenities and comparatively higher economic advantages. Some of these aspects eventually expose the poor in slums to HIV and AIDS through risky means and sources of livelihood unlike the case of those in the middle and upper classes in society. Slums lack good health care services and sanitation for example and other social services.

2.7.3: Slum: An Exclusion Factor

The term slum implies an area with congestion of informal structures and humanity, undesirable living conditions and poor sanitation. On the basis of this description, the term slum is a form of exclusion on its own right. It isolates the inhabitants from the ideal life styles that they deserve. This makes them look like a forgotten human species. People do not choose to live in such dehumanizing conditions but they are rather forced by poverty and low purchasing power to settle in such environments. Slum dwellers spent higher in all aspects of cost since they purchase

all goods in small quantities. More significantly to mention, they are isolated from knowledge and awareness on health issues like HIV and AIDS since they lack extra funds to spent on print and/or electronic media like news papers and powerful TV sets. Protective materials like condoms are scarce as well, and the knowledge and motivation to use them is low. Nutritious food stuffs are out of reach for almost all inhabitants which makes people strong enough especially those on ARV treatment and therapy. Hygiene is extremely bad due to poor sanitation, which is partly an effect of poverty and lack of Government and other sympathizer's support. Slums lack electricity or depend on illegal connections. Social security is deplorable. Physically, people are isolated from the rest of the world since they are poor with low economic power. They lack land tenure rights, others possess land ownership and user rights. In all aspects, living in an informal settlement excludes one from the basic habitable conditions. This theory helps this study illustrate that slum inhabitants are isolated from the mainstream society since they are poor. They lack essential amenities which expose them to inhuman diseases like HIV and AIDS. As the slum excludes them, poverty does the same. Poor environment excludes while poor housing does. All these forms of exclusion leads to human devastation.

2.7.4: The Systems Theory

According to Bertalanffy (1969, 1976 and 2005) systems thinking is the process of understanding how things, regarded as systems, influence one another within a whole. This is an approach to problem solving where problems are viewed as distinctive parts of an overall system. System thinking is not one thing as Bethany (2008) argues, but a set of habits and corresponding reactions of various internal and external elements and practices. The component parts of a system can best be understood in the way they relate to each other whether they are directly or indirectly connected. Where parts of a system are loosely linked, the problem persists since the essential parts are not coordinating in unison to make the whole fully stable and functional. An improvement of one aspect of the whole (problem) can greatly affect another part of the system making it better or worse. In addressing the effects of HIV and AIDS on the the youth in poor slum households and how they cope with these effects, there are many actors and stakeholders that come into the feature. People who are affected by these health challenges are born and live in families that are complex systems on their own right. The families are social units of larger ethnic groups that exist in a country with its political system and administrative

structure. They seek for help in medical centres that are diverse and equally dynamic in operations all of which influences the rate at which the poor who are affected by the scourge access help or miss it. The many stakeholders in the HIV and AIDS arena reflect a real complex system that requires good coordination and supervision for it to function properly. At the international level there is the donor community through the Global Fund (GF) who are financing most AIDS activities under the Sustainable Social Development Goals (SSDGs) platform. At the National scene there is the Government through National Aids Control Council (NACC), NGOs, Faith Based Organizations (FBOs) and the private sectors; who run major drug stores and distribute ARVs and other AIDS care materials. At the grass-roots there are the numerous Community Based Organizations (CBOs) and neighborhood associations that offer socioeconomic and psychosocial support and home based care for those who are infected and orphaned at the households. If all these actors were well coordinated, the effects of HIV and AIDS to the youth would be effectively addressed and the adverse coping mechanisms like commercial sex, subsistence abuse and crime would be adequately controlled. This is therefore a relevant theory to this study.

2.7.5: The Dependency Theory

This is a body of social science theories that were initially advanced by South American scholars among them an Argentinean Raul Prebisch (1901-1986) and a Brazilian Celso Furtado (1920-2004) among other contemporary thinkers. These theories predicted a notion that resources usually flow from a "periphery" of poor and generally underdeveloped states to a "core" of wealthy states, enriching the latter at the expense of the former.

It is a popular contention among the key proponents of these theories that the poor states are impoverished due to persistent exploitation by the rich nations that continue to enrich themselves out of cheap raw materials, huge market for their products like computers, mobile phones, cars and cheap labour from the poor states; which offers a ready market for the advanced technology and products from those rich and economically advanced states because of the way the poor states are integrated to the "world system" where they can hardly fairly compete with their counterparts.

The theory arose as a reaction to the earlier modernization thinking, which held that all societies progress through similar stages of development; hence the underdeveloped nations were

expected to follow the same development path as did the already rich ones since they were in a critical stage of growth where the wealthy nations were some years back.

This "path" it was presumed would spur and accelerate the poor nation's economic growth through investment, technology transfer and above all closer integration in the world market. Gunder Frank (1978) disputed this view arguing that poor states were not just primitive versions of development but had their unique features and characteristics of their own which if well manipulated could make them stand out on their own, unlike the assumption that they ought to follow the foot steps of the rich European and American states. Besides, Frank further speculated that the poor states were the weaker members of the world economy, a position that subjects them to further exploitation. These critiques felt that the underdeveloped countries in essence needed to reduce their connectedness with the world market so that they could pursue a path that was more in keeping with their peculiar needs and potentialities. After all, the Newly Industrialized Countries (NICs), particularly the Asian Tigers (ATs) never followed America or Europe to develop! But they compete with them in the world market.

This theory is important in this study in a number of ways. First, Kenya being a poor country, almost all the ARVs are actually imported or donated from the developed world which signifies a fluid dependence and dominance. There is an assumption that since the rich states continues to generate their wealth from poor countries (Kenya provides cheap coffee, Tea, pyrethrum, labour and a huge market for cars, computers, spare parts etc), those rich countries have a moral responsibility to support her (Kenya) address the effects of HIV and AIDS on her society especially the poor in slums. Thus NGOs from those rich states should invest in assisting the poor who are affected by HIV and AIDS. Slum residents are casual workers in local industrials who supplement their meager incomes with social support from NGOs which are donor dependent as well. As the government depends on developed countries for loans, grants and policy, the poor who are affected by HIV and AIDS depend on the same governments and foreign NGOs for social support and survival. Individual households depend on borrowing from one another. It is a chain of dependence from the international-National-local-individual levels that is not easy to be avoided.

This study holds that it is only when extreme poverty would be broken through genuine social support and empowerment systems, good governance and infrastructural development that dependence would be fully addressed. Kenya is now a middle income economy, which implies

that with steady commitment, proper planning and governance, and investment, soon the country will be a donor and not rely on foreign programme and project aid.

CHAPTER THREE

3.0 EMPIRICAL PART

3.1 Introduction

This part comprises of chapters three, four and five. This is the practical section, which respondents to the gaps indentified in the literature review. It presents the statement of the problem as justified by the major gaps (the background of the whole study was described in chapter one). It highlights the objectives of the study, the guiding questions, the key variables, indicators and how they were measured, and justification of the study. It examines the significance and limitations of the study. The methodology adopted in data collection, analysis and presentation are described in detail.

3.2 Statement of the Problem

The study set-out to investigate the contribution of HIV and AIDS scourge and its management on the poverty incidence in Kenya. A large proportion of the countries revenue and foreign aid is invested on the management of HIV and AIDS, with little allocation on poverty eradication measures which is as an effect of the disease. The existing literature shows that chronic poverty was a serious economic challenge even before HIV and AIDS and its consequences emerged in Kenya. However, poverty has tremendously increased during the advent of HIV and AIDS. Nevertheless, the coping mechanisms of the poor at the household level in slums, and how they adapt to social challenges posed by the disease are somewhat speculative. The study further intended to explore the extent to which households' livelihood security systems have been aggravated by HIV and AIDS crisis, particularly in slums. The nature of poverty emerging from HIV and AIDS and its effects on the economy would be analysed in order to generate practical theoretical and statistical framework of indicators that could be used in addressing the challenge locally and internationally. The study evaluates the practices and experiences of international social funds committed to fight the scourge elsewhere in developing countries to draw potential lessons for the poverty eradication process in Kenya and the region. In order to initiate long-term control measures to curb further impact of the disease on various categories of society, it is important to investigate how the disease affects the poverty situation of different sectors of

society. This is important in generating data on practical interventions that could be incorporated into national HIV and AIDS programmes in order to reduce the rate of poverty arising from the disease.

Kenya like other countries is facing a severe social and economic crisis due to the impact of HIV and AIDS. Protracted morbidity and mortality due to the disease is costing the country not only financial pressure, but also great lose of valuable skills, experiences and potential future leaders. The catastrophe emerging from orphaned children and the high rate of poverty calls for an immediate, proactive plan of action to avert the situation on sustainable basis, at least on the long-term. This situation is worse in the slums in Kenya, where livelihood systems are serious constrained. Surprisingly, in the country different interest groups have had different views and perceptions on how to confront HIV and AIDS endemic, yet the poverty rates associated with the disease have not been precisely investigated and documented. While the government is increasingly pragmatic about the disease, some religious groups are still opposed to some of the methods of intervention. In particular they are opposed to introduction of some details on reproductive health lessons in the education system in the country and condom use as a control and contraceptive measure.

The Catholic leadership however, seems to have changed their stance, after the Pope Benedict the xvi gave an indication that condoms may be desirable in certain circumstances (Nation Newspaper, 6, 20, 2010). However, there has been no official communication from Vatican authorising the Catholic faithful to use condoms to prevent HIV and AIDS transmission in society. May be; the current leader of the Catholic church, Pope Francis who is viewed as much more rebel would give the final consent. Other religious groups have not approved these methods publicly either. These religious institutions are suspicious about what they see as encouraging free and irresponsible sexual interaction especially among the youth, if the condom was made freely available to them. They are therefore in fierce confrontation with civic institutions, individuals and the private sector (including the media) who in their view, are seeking to prevent HIV and AIDS through approaches which '...erode as they claim, the moral and spiritual values of the society' (Kenya Times, Nairobi, 2008). Nevertheless, the poverty situation alongside HIV and AIDS management are less discussed and effectively addressed.

This study assumes that with clear understanding about the nature and extent of poverty caused by HIV and AIDS, it would help policy planners to spearhead development initiatives in designing innovative action plans to reduce poverty increase in rural and urban areas in the advent of the disease.

The existing policy guidelines on poverty and HIV and AIDS eradication seem to be at parallel pathways. To what extent the policy framework protects the poor alongside the fight against HIV and AIDS are little known. To influence the overall social transformation in society, policy formulation and its management plays an essential role in ensuring sustainable economic growth and development. The policy framework set to target HIV and AIDS related poverty in slums if any, would be analyzed to assess its effectiveness in addressing these duo challenges.

3.3 The objectives of the Study

To examine the nature and extent of poverty caused by HIV and AIDS in the slums in Kenya

To explore how the poor in slums cope with the negative effects of HIV and AIDS in enhancing their livelihood security

To determine the targeting procedures used in poverty reduction in HIV and AIDS intervention projects in slum areas

To explore the existing policy framework and how it protects the poor in HIV and AIDS related interventions.

To explore the nature of poverty associated with HIV and AIDS in Kenyan slums.

3.3 Research Questions

Q1. What is the nature and extent of poverty as a result of HIV and AIDS in Slums?

Q2. How does the poor in slums cope with the negative effects of HIV and AIDS in enhancing their livelihood security?

Q3. Which targeting procedures are used in poverty reduction in HIV and AIDS intervention projects in slum areas?

Q4. What is the exiting policy framework and how does it protect the poor in HIV and AIDS related interventions?

Q5. What is the nature of poverty associated with HIV and AIDS in Kenyan slums?

3.4 Operationalization of Variables

This section provides a framework used in the analysis of the core variables drawn from each study question, and the indicators used to measure each variable in the field.

#	Variables and Indicators for measurement per study Question		
	Independent Variable	**Dependent Variable**	
Q1	Nature of poverty • Lack of basic needs • Lack of income • Inability to acquire drugs • unemployment Extent of poverty • Ability to fulfill basic needs • Assess sources of income • Assess levels of income • Examine those affected most • Assess sources/ level of income	**Variable** HIV • Voluntary confession of being HIV+ • Being on ARV, Diet AIDS • Voluntary confession of living with AIDS • Member of AIDS group	**Measurement** • Ability to buy diet food • Ability living conditions • Assess living conditions • Assess their condition s • Being on diet/ ARV • Assess group therapy
Q2	The Poor in Slums Those living with HIV & AIDS and have no Jobs/ income/ employment Inhabitants of the slums are poor Renting shanties in the slum Walking to and from work Sharing rooms to raise rent Children selling items: peanuts, bananas, water, food, begging	Coping with HIV & AIDS • Activities to control stress/ suffering • How people manage the effects of HIV and/ or AIDS • How people survive • Social security	• Sources of income • Assess nature of activities to manage HIV/ and AIDS • How diet/ ARVs are acquired/

		• Sale of ARVs • Commercial sex • Keeping orphans	used • How poverty is addressed
Q3	<u>Targeting procedures</u> Examine how people living with HIV & AIDS are specifically targeted for support to safeguard them from poverty or its effects Examine whether there are any interventions meant to reach those living with the scourge in slums and how they are identified, selected, included assisted	<u>HIV & AIDS related Programmes</u> • Examine initiatives to protect those with HIV & AIDS like free ARVs • Free diet foods, • Free medicine for opportunistic diseases	• Ascertain how poverty is measured • Observe criteria of identificati on • Assess selection process • Assess selection process
Q4	<u>Policy Framework</u> Examine existing policy guidelines on poverty and HIV and AIDS	<u>Protection of the poor affected by HIV & AIDS</u> Examine how the existing policy is applied in safeguarding the poor who are affected by HIV and AIDS	Assess how policy targets those affected by HIV and AIDS Nature and amount of resources targeting those households that have lost a person to aids Scholarships and other assistance to orphans
Q5	<u>Nature of poverty</u> Examine the kind of poverty that is associated with the effects of HIV and AIDS	<u>Effects of HIV and AIDS</u> Effects of chronic illness due to HIV Effects of early retirement or death as a result of AIDS	High expenditure on diet by approximated percentage given orally, medicine thus making a family unable to live happily Inability to educate children due to early retirement due to AIDS Withdrawal from

			school due to death of parent(s) Sell of family property (land)(estate)(cars) due to lack of income

Other key variables for measurement

1.	Targeting Error	• Missing those affected by HIV and AIDS, • Assisting non poor • Help to people without HIV and AIDS	• Observe likely errors in selection • Observe errors in provision of assistance • Determine level/ decree of error
2.	Safety-nets	• Support mechanisms • Interventions to help people with HIV and AIDS in slums	• Observe sources • Assess nature of support/ Help given • Whether support reaches deserving people living with HIV and AIDS or directly affected members

3.5 Description of the Study Sites

3.5.1 The Kibera Slums

Kibera is derived from a Nubian word "Kibra" meaning a '*forest*" or '*jungle*'. Nubians are a small community who are believed to have migrated to Kenya from Southern Egypt and Northern Sudan in 1950s. The slum was allocated to the Nubian soldiers who had returned from the Kings African Rifles (KAR) a multi-battalion British colonial regiment which was raised from various British conies in 1902. These are the soldiers who were being prepared to protect the British interests in different parts of the Eastern Africa for both military and security services. British crown gave the Nubian soldiers Kibra as a gift for their service and dedication in protecting the British interests and dominance. They were kept away from the city centre probably for the rulers to avoid unnecessary pressure from the poor ageing retired soldiers! Nubians initially settled in Nairobi after their families were displaced by the Aswan dam in

North Sudan. Kibra is situated 5 kilometres south west of Nairobi city centre. It is the largest slum in Nairobi and the largest urban informal settlement in Africa and the third ranked globally. According to the national census 2009, the slum is home of 170,070 people, although earlier studies by UN-Habitat had suggested a population of between 600,000 to over 1million people. However this population size is still disputed.

Given that there are about 132,000 dwelling units (See Un-Habitat, 2013(b)) with an average of at least 6 household members in each shanty, we hold that to date the slum has a higher population than 792,000 people. However it's important to note that the actual population of this slum is still unknown given the fluid mobility nature of human population. Kibra is sub-divided into nine villages that are characterized by the major ethnic communities in Kenya namely; Kianda, Soweto East, Gatwekira, Kisumu Ndogo, Lindi, Laini Saba, Siranga, Makina and Mashimoni. The inhabitants of this area are by no doubt extremely poor. They survive on illegal electricity connections which are sublet to them by underground traders. Water is largely supplied by private vendors which cost between Kshs. 5 and 30/- (US$ 0.06 to 0.35). The safety standard of the water cannot be known since it is sometimes drawn from sewage ponds. House rent ranges between Kshs. 400 (a bed sitter shared by 4 tenants) and 2000 for more affluent tenants (US$ 4.7 to 18) per unit. There is poor sanitation and garbage littered all over. Although the inhabitants have a number of pay-as-you-use community or youth run and managed pit latrines and bathrooms, '*flying toilets'* (the phenomena where people relief themselves in polythene bags, and then throw the bag on the streets or house roofs are quite common due to the high cost of toilet use ranging from 10 to 20 shillings (higher than other slums). It is also a security threat especially for women to go to the toilet at night, which are built like 20 to 50 metres away from the houses. Many have been gang-raped on the way to the toilets in the past according to Kisiah (2012). Most of the residents of Kibra walk to and fro the industrial area to seek for casual jobs daily, which are not guaranteed. The area was selected for this study due to the high population, poor living conditions, high HIV and AIDS prevalence and poverty incidence. Kibera's proximity from the researcher's place of work, the Catholic university of eastern Africa was also a motivating factor.

3.5.2 Mukuru Kayaba Slum

It is situated about 4.2 kilometres South East of Nairobi city centre in Viwandani (industrial area) location. The area was covered by Kay apples vegetation which was translated by the native habitants to mean "kayaba". It covers a spatial area of approximately 20Kms. The living units continue to be sub-divided to accommodate new immigrants. Tenants pay rent ranging from Kshs. 800 to 2500 (US$ 10 to 30) per month which is not easy to raise for the most inhabitants who are perennial casual workers, whose jobs are not guaranteed every day. The slum has a population of about 75,000 people living in close to 4125 housing units (UN Habitat, 2013(b)).

The area has few privately owned pit latrines which cost 10 shillings per use (US$ 0.12). Since most people lack this money, flying toilets are the most preferred alternative. Garbage is thrown on the roadsides. There are a number of small poorly equipped medical clinics run by unqualified paramedics. However, most inhabitants go to Mary Immaculate Clinic (MIC) for free or subsidised cost. Formal and informal schools run by Mukuru Promotion Centre (MPC) a Catholic religious movement serve most of the needy children from the poor households in and outside the slum. Most people work as casuals in the nearby industrials and Muthurwa Jua Kali sheds (translated to mean working under the hot sun). They innovatively make low cost household products like cooking pots, frying pans and repair vehicles. Women engage in grocery vending and washing of clothes in the middle class houses, besides illegal alcohol brewing and other antisocial activities like commercial sex work at Koinange Street (famous for twilight girls at night). The Street serves as red-light district at the heart of Nairobi. This slum was selected for inclusion in this study to supplement Kibera settlements and compare the effects of HIV and AIDS on the poor in both slums in Nairobi. It has a number of Development agencies working in partnership with the poor community members which provides a good opportunity to observe the coping mechanisms of the poor in the advent of HIV and AIDS. Since Nairobi has more than 13 slums, it was necessary to select more than one informal settlement to represent the others in this city.

3.5.3 Nyalenda Slum in Kisumu

This is the largest informal settlement in Kisumu, which is on the shores of Lake Victoria. It is divided into Nyalenda "A" (extending to Nyamasalia area) and Nyalenda "B" (including 'Pandpieri', Manyatta 'A' and 'B', Obunga, Bandari, Manyatta-Arab and Kaloleni). Initially it

included other potential slum pocket areas like Korando, Kanyakwar and Chiga. Nyalenda “B” is seperated from the affluent Milimani estate by the outer-ring road. This is a rapidly growing area with new maisonettes and short story buildings emerging. It is less crowded compared to all the other slums in the Kenya.

All the villages including west kolwa has a population of about 345,238 (Census, 2009). However, Nyalenda at its core is estimated to house about 123,098 people (UN Habitat, 2011) with an influx of many new arrivals buying and building homes in the area since land is relatively cheaper than in other areas in Kisumu town. Most people particularly women here are fish mongers. They buy the filleted fish in industries commonly known as Mgogo wazi (fish without the fresh) and sale them raw or cooked alongside the main slum streets and foot paths. Others work as casuals in the affluent Milimani area where they do domestic work. Young men operate motorbike and Bicycle transport commonly known as boda boda transport. Petty trading is a predominant source of income. Jua Kali artisanship is also rampant. Most women trade in K’wino market where different wares are on sale.
Poor housing, filth streets with garbage on the road sides is a common feature. The HIV and AIDS prevalence is estimated at 14.8% which is a major social problem in the area especially in Obunga. Kudho primary school has a record number of HIV and AIDS orphans. This figure attracted the researcher’s attention because the slum is rated as one of those with the highest AIDS related deaths in Nyanza region and in Kenya as a whole. Inhabitants are ranked among the poorest in the country as well. These attributes made it an ideal choice for this study. It was also chosen to represent the lake region and Nyanza area.

3.5.4 Bangladesh Slum in Mombasa

Bangladesh is the largest slum in the coastal county. It is located about 5.6kms west of Mombasa Island, in Changamwe District. This informal settlement acquired its name from an Asian immigrant of a Bangladesh origin who is believed to have been the original owner of the land before he left it unutilised and went back to his country never to return. It accommodates an estimated 3018 dwelling units with an average of seven members per household and a population of about 21,000 inhabitants. It consists of six well marked villages with functional elders namely:- Bangladesh centre, Majengo mapya, Nairobi area, Mkupe, Kichimbeni and Giriamani.

The inhabitants constitutes of a multi-ethnic group where each village name denotes the majority ethnic group residing in the area. The Luo, Luhya, Kamba, Giriama and the Kikuyu form the larger communities living in this settlement. Others include Kisiis, Taitas and the Swahili from the Miji kenda community. Most of the people are driven here by poverty hence they cited cheap rent that ranges between Kshs. 500 to 2000 (US $ 6 to 24), cheap readily cooked food stuffs on the main streets and freedom from the police, who are commonly known as "*Magava*" who are never visible on the streets.

Inhabitants claim that less Government presence was the main attraction to settle in this area. The locality is ideal for those who work in the numerous Go-downs (container depots and repackaging sheds) for goods from the Mombasa port. A unique feature one observes along the main street is the high number of elderly business women who are the majority in the slum. This could be attributed to the high number of widows as a result of HIV and AIDS and young single mothers working in the neighbouring estates and factories. This is the reason why this slum was selected as a suitable site for this study. Unlike Kibra and other slums in Nairobi, here flying toilets are not common.
There is high existence of pay-as-you-use pit latrines run and managed by the youth, although they are poorly build. A few public toilets contructed by the Country of Mombasa and the Catholic parish in the slum are available though not adequate. Land tenure system is complex. Residents have no title deeds including the churches, although they have been lobbying over time to be awarded legal land ownership documents. A good number of people are traders on different wares in the slum main street. The rest live on casual jobs and illegal brews like chagaa (traditional spirit), busaa and mnazi (locally brewed traditional alcohol). Commercial sex workers who live here target tourists in town and at the main beaches. Particularly young men target the old tourist grannies, while young underage girls target old retired white visitors for commercial sex. Some have been married through these encounters.

Bangla pesa, a mode of payment by use of locally produced voucher which is a contemporary promissory note to the national currency was in use during our field work. Nevertheless residents were in fear after six of their members had been arrested for introducing illegal currency in the slum. A group of small scale traders, the Bangladesh Business Network (BBN) has taken up the

initiative to supplement the scarce Kenyan shilling which is not easy to acquire and transact business as they claim. The BBN has had about 200 members in their scheme. The vouchers however were unauthorized for use after the police had confiscated the ones that were on circulation. After consistent lobbying and a court case was thrown away with no charges, Bangla pesa has been authorized for use as a supplementary currency in the slum. We selected this slum to represent the coastal region, analyze the impact of HIV and AIDS on the poor in this region and assess how the means of livelihood differs from the other informal settlements in the country. The composition of inhabitants and naming of villages according to the ethnicity of inhabitants just like Kibra raised our curiosity to target this area as well.

3.6 Conceptualising a Dynamic Scientific Approach in Conducting the Study

A dynamic scientific approach involves a way of looking at the world and interpreting what is under the current study. It gives an indication of how research ought to be conducted depending on its focus, extent and to what level of involvement and interpretation as Rubin and Rubin (2005); Mugenda, (2009); and Jwan and Ong'ondo (2011) emphasize. Researchers operate within particular view points to the extent that all of them have a philosophical leaning (a way of interpreting the world through scientific inquiry). This may not be explicit but still influences the research process as Denzin and Lincoln (2005) put it. Denzin and Lincoln argue further, citing Bateson (1998) that all researchers are philosophers in the "universal sense in which all human beings are guided by highly abstract principles in their thinking, which in turn influences their behaviour and character".

Klenke (2008) contends that it is not possible to conduct rigorous research without understanding its view point basis. Thus, a good research inquiry ought to make a clear focus within which it is based to show that researchers are aware of their influence as they conduct an inquiry (Creswell, 2007). There are two main issues to consider with regard to philosophical paradigms in research; which are ontology and epistemology. The researcher's commitment to these two dimensions is critical in framing the research process (Johnson 2008; Klenke, 2008). Denzin and Lincoln (2011) suggest that Axiology is another paradigm that is used to study ethics and aesthetics, which we shall not apply in this study.

Ontology is defined as the nature of reality or the assumptions we have about reality or knowledge, for example our assumptions about the effects of HIV and AIDS on the poor in the four slums under investigation. While epistemology refers to the way reality or knowledge is studied for instance the way we would examine the variables under this study in order to make an argument on the nature of poverty caused by HIV and AIDS in slums in Kenya. The ontological assumptions can be conceptualized along a continuum with two extremes. These are *realism* and *relativism* respectively as Johnson (2008) and Richards (2010) explain.

They further indicate that the realist perspective looks at the world as an *objective* entity that has rules and regulations that govern behaviour; hence, the existence of 'objective truth'. This is why this study examines the nature of existing policy and how it regulates assistance to those affected by HIV and AIDS as a protective measure. The realist's role in research is to be neutral and their purpose is to discover the objective reality on the one hand. While on the other hand, the relativists take a *subjective* position - that there is no single viewpoint of the world and therefore reality is internal to and dependent on the individual's perception and experience (Johnson, 2008). They argue that; it is not only that which is perceived (the way we see the effects of HIV and AIDS on the poor), but that which is interpreted by the individual (the views of the affected poor people by the disease) that forms the truth. Relativists argue that these individual interpretations are deeply embedded in a rich contextual situation that cannot be readily generalized to other settings (Klenke, 2008). Consequently, there is no objective reality but multiple realities socially, economically and culturally constructed by individuals from within their own contextual interpretations (Mason, 2011). This scholar further argues that it is only once people recognize that alternative ontological perspectives might tell different stories that they begin to see their own ontological view of the social world as a position which should be established and understood, rather than as an obvious and universal truth which can be taken for granted.

In this study, we adopted relativist's ontology and interpretive-constructivist epistemology. This is because, as Mason (2011) explains, a relativist's ontology and interpretive-constructivists epistemology seeks to generate information from people themselves, aiming to get knowledge about how people perceive, interpret, and understand issues that affect them in their real life situations. We take the view that the way the people living with HIV and AIDS perceive their

context and the way organizations and people initiating intervention activities to assist them perceive them may differ. This is because in some cases people who are affected by HIV and AIDS are described as 'victims' which creates an impression of negative connotation, rather than seeing them as normal people who are just affected by a health challenge that could be reversed. The same applies to their interpretations of the practices within their living conditions. We also adopt the view that it is by interacting and talking to the respondents, listening to their views and the way they interpret their situations, that we can gain an in-depth understanding of the variations in their perspectives on how they have been affected by the disease over the years, and how they have been coping with its effects at the household level.

3.7 Research design

The study adopts mixed research designs where a survey (quantitative) and naturalist (qualitative) designs with a before-after problem solving evaluation approach were applied. This historical dimension applies a comparative analysis of the poverty, HIV and AIDS trends and coping mechanisms adopted by the poor in slums in the advent of HIV and AIDS in comparison with the situation before. A research design is a plan of action (road map) that shows how the problem under investigation can be treated or resolved (Mugenda, 2009). This study adopts a mixed research paradigm namely quantitative and qualitative. Quantitative paradigm focuses on survey design and the qualitative employs the case study or naturalistic design (where specific slums form the cases under analysis). The two designs were used to collect data from four informal settlements that are treated as cases namely:- Kibra and Mukuru Kayaba both in (Nairobi County), Nyalenda (Kisumu County) and Bangladesh (Mombasa County) whose characteristics are not necessarily similar.

The survey design assisted the researcher to generate empirical data from a large population from which generalizations were conclusively made. Likewise, the survey design provided the researcher with an opportunity to compare and determine the coping mechanisms of the poor who are affected by HIV and AIDS in different ways; and those whose poverty situation is a result of other conventional causes like unemployment and lack of income and capital for investment among others. Naturalistic design or case studies (in distinctive slum settlements) were used to enable the investigator to get a better understanding of the social and economic realities of what the participants do on daily basis to support themselves financially or otherwise

to counteract the effects of living or being affected by HIV and/ or AIDS. This applied like in the case of addressing the agony of the death of both parents who were the bread winners by the orphans. Naturalistic inquiry helped to explore the respondent's perceptions and real life experiences on how they manage the good or bad effects of being poor on the one hand, and being affected by HIV and AIDS on the other. Using naturalist inquiry or specified case studies for observation enabled the researcher to enter into the natural setting of the participants while exploring the individuals' stories based on their life history, daily practices and the broad survival tricks they use to make life not only bearable but fully meaningful. The case study design or naturalistic therefore was predominantly used because it provides in-depth insights on the situation in the past, at present and an overview on what might happen in the future.

3.7.1 The Target Population and Sample Size

Out of an approximated population of about 750,200 people in the four slums, a sample of 250 respondents was initially targeted. Out of this anticipated sample, the researchers were able to access 197 respondents from the general residents in the four slums as follows:- Kibera (55) and Mukuru Kayaba (45) making (100) from Nairobi, Nyalenda (68) in Kisumu and Bangladesh (29) in Mombasa. Other eighteen (18) key informants drawn from the public administrators, development officers, Women leaders, political and Youth leaders, health officials, religious leaders and NGO staff were involved. This constituted a total of 215 respondents which is 86% of the study sample

3.7.2: Description of the sampling procedures

Related to the issue of the number of participants involved in the study is the question of sampling techniques. Mason (2005; Kombo, et al, 2006 and Mugenda, 2009) define sampling as the way through which the actual participants to respond in interviews are identified, selected and accessed. These scholars emphasize that the process needs to be done carefully because it has implications on the trustworthiness of the findings. Mason (2005) acknowledges that "*the conventions of sampling in qualitative research are less clear-cut or well established than for statistical and quantitative research*". That notwithstanding, the above scholars *(ibid*), content that sampling in qualitative research is mainly guided by two principles; - 'practicality' and 'focus' of the study. They therefore, recommend the use of strategic sampling. This is the type of sampling that targets a relevant range of contexts, participants or characteristics related to the

issue under investigation. For the survey, stratified random sampling technique was strategically used to determine the specific households to be included in the study from each street in the slums. The streets served as strata in each slum. This particular technique was preferred because it involves categorising the population into homogenous groups, each group containing subjects with similar characteristics as (Cohen, et al, 2011) put it. This therefore ensured that the sample selected in each cluster of houses is representative of the population to allow for generalisation of the findings. This is adopted in this study due to the dynamic nature of the coping and survival tricks of the poor who are affected by HIV and AIDS in slum settlements. The nature of livelihoods and cost of living in the slums selected in this study are equally different.

Likewise, we applied non probability sampling technique based on a purposive sample. We identified and went for the most accessible key and general respondents who possessed the information related to this study; and the one we would spend most time with. We focused on participants who were likely to provide rich and in-depth information on how the poor managed the impact of HIV and AIDS and the kind of socio-economic support they receive as a social security measure. This was crucial to determine the nature of poverty associated with HIV and AIDS by those who are affected in one way or another.

3.7.3 Data Collection Instruments

Data were collected partly by use of structured observation. Observation guides were used to observe and record the some of the visible survival activities that people living with or affected by HIV and AIDS were involved in at the household level. Questionnaire(s) were widely used in guiding interviews and recording responses from the general respondents and key informants. This was useful in organising responses in order of merit which made it easy during coding and entry into spreadsheets. This was ideals since it helped in using both open and closed items for both specific and general issues that were being discussed. With respondent's permission and consent we recorded some of the focus group discussion in tape recorded so that we would remember the issues that were being discussed during transcribing exercise. We also look some photographs as evidence of some of the living conditions and survival mechanisms with written consent of the respondents. Key informant's guides were really hard in guiding open discussions with professional in different sector within the Government, NGOs and the private sector.

3.7.4 Testing Validity and Reliability of data Collection Instruments

Prior to embarking on the actual data collection exercise we first conducted a reconnaissance survey at Kibera Slums one of the study sites to pre-test the validity and reliability of the instruments. During this initial activity ten (10) respondents from the infected and the affected category and two (2) key informants were interviewed. All the tools were used here to have a feel of how respondents understood and responded to the items, as well as how long each toll took to administer. We discovered however that the tools were to long, took more than an hour to fully complete and some items were not were understood. We then reviewed and reduced the items and pre-tested the tools again in Mukuru Kayaba with a half the number of the respondents we had involved during the first pre-testing exercise. This way we were certain that each item was better understood and on average the longest interview took between 30 and 40 minutes.

3.8: Description of the Data Collection Methods and Procedures

3.8.1: Qualitative Approach

A qualitative method is distinguished from a quantitative one by its emphasis on a holistic and descriptive treatment of phenomena as Stake (2011) emphasizes. It sees the world as interconnected and context sensitive. Qualitative research involves in-depth interviews and/or observations of subjects in their natural and social settings (Litchman, 2013). In this study we sought answers to questions that explored how people survived on the effects of HIV and AIDS and how their social experiences are created and given meaning. This requires being in interactive contact with the participants in their socio-economic set-up. Consequently, Hammersley *et al*. (2012) observe that if researchers are to understand people's outlooks and experiences then they must:- be close to real life conditions, look at the world from their respondents' viewpoints, see them in various situations and in various moods, appreciate the inconsistencies, ambiguities and contradictions in their way of life. This method helped us to explore the nature and extent of the participants' concerns, understand how they have been affected by HIV and AIDS and how they have been coping with those effects. Qualitative research was suitable for this study because its ultimate aim is to generate ideas and concepts that offer to cast new light on the issues being investigated from the viewpoint and experience of the affected members of society. Although qualitative research tends to work with a relatively small number of cases thus sacrificing quantity for detail, in this study, the coverage of four

research areas was not so wide (thus qualitative) but focused on enough detail without too much duplication and repetitive information being gathered.

3.8.2 Quantitative Approach

We used mixed research by integrating qualitative approach on the one hand and quantitative method on the other; because the later allows for control, objectivity, generalization, outcome oriented, and assumes existence of facts which are somehow external to and independent of the researcher as Mugenda (2009) and Gillham (2010) indicate. An essential advantage of quantitative approach in this study is that it helped us produce numerical values to justify the quantities and the number of respondents whose perceptions were generated for statistical analysis through interviews. Quantitative data provided us an important opportunity to produce frequencies to categorize different views according to their weight and strength as they were relayed by the affected people. Quantitative strategy also allows working with somewhat large quantities of data for detail which was anticipated in the four slums selected for this study.

3.8.3: Interviewing Method

Interviewing is a technique of generating data that "involves gathering information through direct verbal interaction between individuals" (Cohen et al., 2012). We used a set of questionnaire with both open-ended and closed-ended questions to elicit obvious and the information that required further probing. This tool helped the researcher to understand what the respondents were thinking about and their attitudes in order to explore a person's reasons for behaving in a certain way or for carrying particular perceptions or attitudes on how the poor manage to live with HIV and AIDS. Since this method deals with issues of personal and social nature it allowed participants themselves to provide insights on their real life experiences in an interactive and discussion process. A Questionnaire allowed the researcher to systematically ask the same questions to all the respondents for uniformity and consistence in order to see where contradictions emerge or similarities exist.

3.8.4: Observations and Informal Conversations

We incorporated observation in all the other methods of data collection so as to use our vision to confirm what the respondents were narrating, listen and watch their emotional reactions and witness particularly their living conditions and relate them to their feelings. This method gave us an opportunity to watch the sources of income, businesses and the size of the stocks and items

our clients were selling and drew deeper understanding on what they meant through their expressions. We also keenly observed the surrounding and living units. This was better than relying on second hand information and reports. We would ask to clarify issues and probe claims for clarity. Observation was an important source of additional evidence on what respondents were telling us. This method revealed what people actually do but never said they do. We therefore used observation guides to take note of the issues that were not verbally discussed or needed confirmation as they were being presented by the respondents.

3.8.5: Focus Group Discussions (FGDs)

In Focus Group Discussions (FGDs) we made prior arrangements with pre-existing self-help groups identified through church movements and/or NGOs. In all the slums, community leaders introduced us to formal groups that were already operational. By used of a FGD guide with a few issues to guide the discussion, we facilitated discussions with small groups of from four members to nine members. In some groups the membership was higher than sixteen since these were pre-existing teams. People in groups spoke without fear and they could correct each other along the way. They also discussed issues freely collectively as if they were affecting each one of them in the same way. They clarified certain contradictions that had emerged in individual interviews. We also used unstructured questions that generated heated debates on what people who are affected by HIV and AIDS should do to be self reliant in life. This data collection tool helped to bring out respondents' spontaneous reactions and deep-rooted ideas.

3.9 Description of Data Analysis Procedures

Different scholars define data analysis in various ways. According to Richards (2009) and Yin (2009), data analysis involves keenly and critically looking at the raw or secondary data, assigning it categories and putting together emerging issues into themes in an attempt to answer the research questions. Yin (2011) further observes that data analysis is not easy because there are no specific universal steps of doing it even where computerized packages exist. He further argues that analysis of any data varies depending on research focus, methods of data collection used, the type and amount of data available. Stake (2012) adds that there is no particular moment when data analysis could be underrated since it is a matter of giving meaning to first impressions as well as to final compilations of study findings. The Statistical Package for Social Sciences

(SPSS) was extensively used to process the quantitative data. Percentages, Means and averages were used to determine the quantifiable information and make conclusions.

For qualitative data, thematic analysis technique was used. As the name suggest, it is the search for themes of relevance to the research topic under which reasonably large amounts of data from different sources such as observations, interviews, conversations and reports were organized to derive meaning on the study questions. We applied this method by first carefully sorting and listing the categories of experiences from the transcribed data and field notes then identifying all the data that illustrate the categories. Related categories were then combined into themes. We then categorized the themes drawn from the key informants' responses together to form a comprehensive picture of their collective experiences and stance on the impact of HIV and AIDS on the poor. We had first to build valid arguments for choosing the themes by reading and making inferences from literature. Informants' themes focused on their observations, interventions, counter effective strategies and key policy issues and the experiences they have had in their sectors as they serve people living with HIV and AIDS in slums. Our actions were informed by the work of Braun and Clarke (2010) who pointed out that a theme captures something important about the data in relation to the research question and it represents some level of patterned response or meaning within the set of data being processed. Abel Mugenda (2009) ascertains that data coding to some extent, depends on whether the themes are more data-driven or theory-driven. In the former, the themes depend on the data, but in the latter, the researcher might approach the data with specific pre-existing questions from reports in mind that he or she wishes to validate through raw data from the field. To generate evidence on the coping and survival tricks of the poor who are affected by HIV and AIDS in one way or another, qualitative data analysis process involved six key stages, namely:-

1. Data Transcribing
2. Familiarizing and understanding the data
3. First phase Coding
4. Second Phase Coding
5. Third Phase Coding
6. Report writing

The transcription involved turning data from the verbal and observation notes into the written mode. A lot of this took place during the data processing stage. The process enabled the researcher to engage with and internalize the emerging information. At this stage, the researcher ensured that the transcripts captured as much as possible the true version of the information gathered from the respondents.

We then went through the process of reading the transcripts from each interview. This helped in forming a general idea of what the data is saying as well as our initial thoughts (interpretations) regarding the data. After the initial reading, re-familiarizing with the data, we then coded it by highlighting the extracts of the transcribed data and labelling based on the various categories we had identified. These are; those who had declared themselves as HIV positive, those living with AIDS, Orphans who had lost their parents, Half orphans, relatives (grand-parents, brothers and sisters) who had taken responsibility of care providers, general inhabitants in slums, key informants, administrators, NGO and health staff and religious leaders.

3.10: Data presentation

The data is qualitatively and quantitatively presented. Frequency tables, pie charts and graphical methods are used for the quantitative data generated through the household survey. Qualitative presentation is applied mainly for the data collected from the open-ended items and focus group discussions. This permits for in-depth presentation of the issues which might be ignored in tabulation records. Verbatim quotes cited in the report present information as presented by respondents in its real form as expressed. This reveals the peoples' emotions and true life experiences in the report.

CHAPTER FOUR

4.0 Data Analysis, Interpretation and Presentation

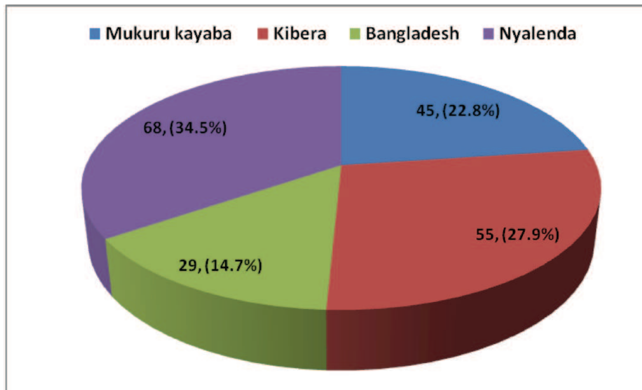
4.1 Introduction

This chapter deals with data analysis, interpretation, discussion and presentation of the findings in relation to the main questions guiding the study. Qualitative data is presented in descriptive explanations while quantitative data are presented in form of pie charts, bargraphs, frequency tables and histograms in order to highlight the general trends of the frequencies for comparison reasons.

4.2 Demographic Chracteristics

4.2.1 Demographic Characteristics of The Respondents

Figure 1: Distribution of the general Respondents based on the slum of residence

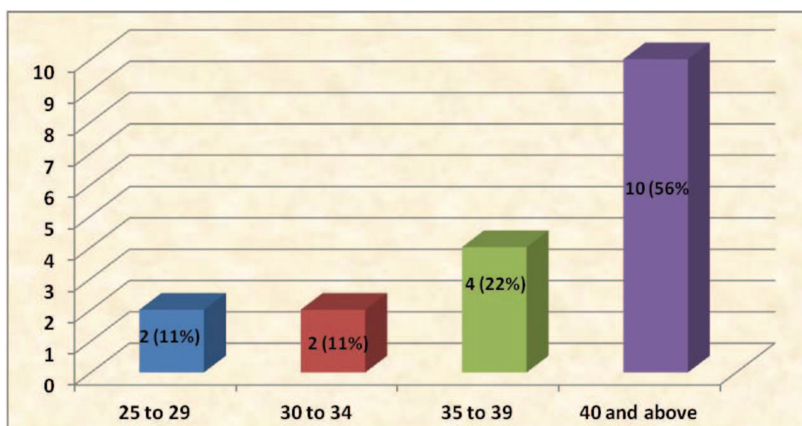


As shown in figure 1 above, the study involved 197 people living in the slums and 18 key informants drawn from the Government and other service delivery organizations making a total of 215 respondents. Out of the general respondents the majority 68(34.5%) were drawn from Nyalenda slum in Kisumu, followed by Kibera with 55(27.9%) and Mukuru Kayaba 45(22.8%) respectively both of which were selected from Nairobi county. In the smallest slum (in geographical size and population), Bangladesh in Mombasa 29(14.7%) respondents were involved in the study. The two slums in Nairobi had the highest representation of 100 since the

city has many other slums that were not targeted in the study. More respondents were drawn from Nyalenda because the residents were more open and ready to participate in interviews. They would guide the researchers to other organized groups of widowed mothers, destitute youths and children orphaned by HIV and AIDS who were running socioeconomic activities to empower their members in the slum. It is also a vast area compared to the other informal settlements in the study.

4.2.2 Demographic Chararcteristics of The Key Informants

Figure 4.2: Distribution of Key Informants by Age-group



As figure 2 above illustrates, out of the 18 key informants, 10(56%) were above forty years of age followed by 4 (22%) who were between 35–39 age – group. This could be explained by the fact that most organizations are headed by mature experienced chief executive officers who have been in the field for quite some time. The rest were between 25-29 and 30-35 with 2(11%) each respectively. This implies that some organizations preferred young leaders and coordinators. An elderly women church leader in Nyalenda, Kisumu claimed *"….In the church, I have been a chairperson of our Jumuia 'small neighbourhood prayer group' for six years. You know in the church, we have different groups; upper, middle and lower categories in terms of income and social status. We have witnessed bread winners die, wives following in less than a year and children who were socially and financially secure becoming orphans. They start to struggle to survive here in all manner of ways! We have seen children turn into lobbers, casual labourers*

and others turn into fish mongers. Once they venture the sex industry, they die in less than five years, just like their parents did".

In Bangladesh, Mombasa a religious leader claimed that the poor especially those infected or affected by HIV and AIDS survived on church food rations and retroviral drugs and treatment. Many sort for school fees, clothing, and medical care and worked as community mobilization leaders. He argued that unemployment of these people led to increase in crime rate. Drugs and subsistence abuse led to addiction and crime was cited among the urban youth. A District Development Officer (DDO) in the area claimed that,

> *"Among the wealthy, we wouldn't know whether they had been affected or infected with HIV and AIDS until they begin falling sick. They provide for themselves, unlike the poor who come to us to seek assistance. Its not that the rich are not infected or affected. They take care of their people. However, we have buried many here. I have to confirm nevertheless, that the higher number of the infected is in slums. This is because when people loose their jobs due to AIDS, they rush to settle in slums where accommodation is relatively lower. As I have stated earlier, it doesn't mean that posh areas like Lavington or other elite estates like Muthaiga or Runda do not have People Living with HIV & AIDS (PLWHAs) but the worst affected are those in the slums as we have seen here, since they have poor diets and are ignorant when it comes to use of ARV drugs. They also live in poor environments. This predisposes them to diseases making them more susceptible to infections"*

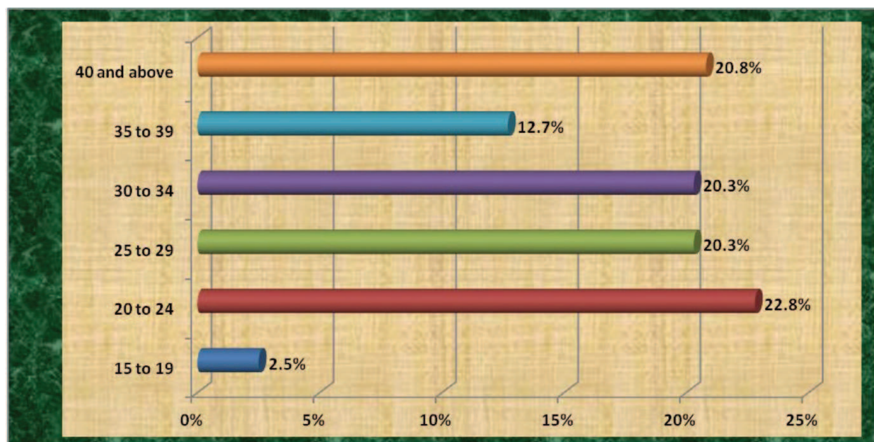
Table 1: Distribution of the Respondents based on Gender and Area of Residence

Gender		Location				Total
		Mukuru Kayaba	Kibera	Bangladesh	Nyalenda	
Male	f	30	28	16	28	**102**
	%	15.2	14.2	8.1	14.2	**51.8**
Female	*f*	*15*	*27*	*13*	*40*	***95***
	%	7.6	13.7	6.6	20.3	**48.2**
Total (n)	***f***	***45***	***55***	***29***	***68***	**197**
	%	**22.8**	**27.9**	**14.7**	**34.5**	**100**

As shown in table 1 above, out of the 197 general respondents, majority 102 (51.8%) were men whereas women represented 95(48.2 %). In the slums more men were available for in-depth

discussions during the day, which was associated with the fact that most of them worked during the night as security guards or casuals in industries that operated 24 hours especially in Mombasa where offloading cargo from ships is done round the clock.

Figure 3: Distribution of the general Respondents on the basis of Age-group



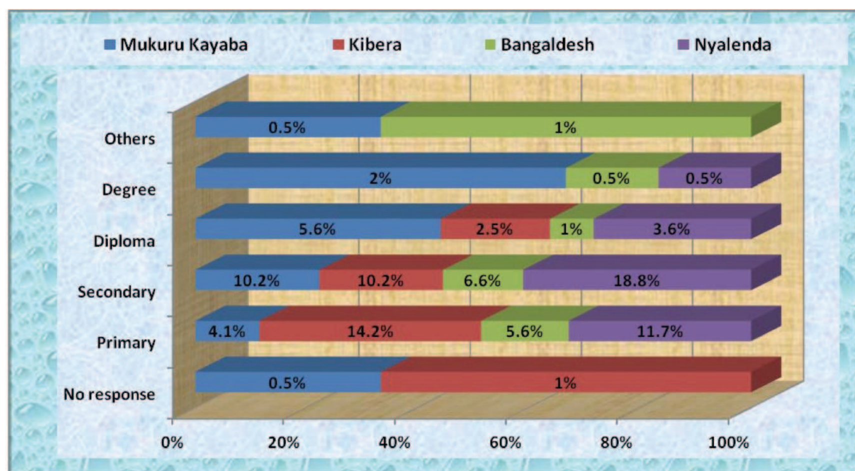
In Bangladesh Mombasa, some men were working as casuals or drivers in the night shift at the port. A comparative analysis of the two genders across the slums revealed that in Mukuru Kayaba, males were 30(15.2%) to 15(7.6%) females. In Kibera slums 28(14.2%) to 27(13.7%), while in Bangladesh they were 16(8.1%), to 13 (6.6%) and finally in Nyalenda in Kisumu males were fewer than females at 28(14.2%) to 40(20.3%) respectively. Asked about their age-groups as indicated in figure 3 above, 1(0.5%) of the respondents declined to respond. This is associated with the fact that most middle aged females tend to be uncomfortable disclosing their age. Of the remaining respondents, 5(2.5%) indicated that they were aged between 15 to 19 years, 45(22.8%) were aged between 20 to 24 years, and 40(20.3 %) were aged between 25 to 29 age-group, while 40(20.3%) and 25(12.7%) were aged between 30 to 34 and 35 to 39 years respectively. Accordingly, the percentage of respondents aged 40 and above was 41(20.8%). This representation reveals that there were more respondents aged 40 years and above, because the study targeted more mature working adults residing in slums who were living or were affected by HIV and AIDS in one way or another since they had the required information.

Table 2: Distribution of the Respondents Based On Their Age and Area of Residence

Age		Location				Total
		Mukuru Kayaba	Kibera	Bangladesh	Nyalenda	
No response	*f*	*1*	-	-	-	***1***
	%	0.5	-	-	-	**0.5**
15 to 19	*f*	*3*	*1*	*1*	-	***5***
	%	1.5	0.5	0.5	-	**2.5**
20 to 24	*f*	*15*	*17*	*5*	*8*	***45***
	%	7.6	8.6	2.5	4.1	**22.8**
25 to 29	*f*	*8*	*11*	*6*	*15*	***40***
	%	4.1	5.6	3	7.6	**20.3**
30 to 34	*f*	*7*	*10*	*7*	*16*	***40***
	%	3.6	5.1	3.6	8.1	**20.3**
35 to 39	*f*	*4*	*5*	*4*	*12*	***25***
	%	2	2.5	2	6.1	**12.7**
40 and above	*f*	*7*	*11*	*6*	*17*	***41***
	%	3.6	5.6	3	8.6	**20.8**
Total (n)	***f***	***45***	***55***	***29***	***68***	***197***
	%	**22.8**	**27.9**	**14.7**	**34.5**	**100**

As summarized in table 2 above, the percentage distribution of the age group 15 to 19 years in Mukuru Kayaba was 3(1.5%), and 1(0.5%) respectively in Kibera and Bangladesh. This age-group did not have respondents in Nyalenda in Kisumu because between 15 and 19 years in this area were students in high schools or college, unlike in the other slums were idle youths were readily available on the streets during the day. The distribution of those aged between 20 to 24 years in Mukuru kayaba were 15(7.6%), Kibera 17(8.6%), Bangladesh 5(2.5%) and Nyalenda had 8(4.1%) in that order. Those aged between 25 and 29 years were 8(4.1%), 11(5.6%), 6(3.0%) and 15(7.6%) for Mukuru kayaba, Kibera, Bangladesh and Nyalenda respectively. Respondents under the age category of 30 to 34 years were 7(3.6%), 10(5.1%), 7(3.6%) and 16(8.1%) in the same localities. Age group 35 to 39 years had the smallest representation since most people were at work when the interviews were being contacted. They had 4(2.0%) for Mukuru Kayaba and Bangladesh respectively and Kibera had 5(2.5%) while Bangladesh had 12(6.1%).

Figure 4: Distribution of Respondents according to the Level of Education and Area of Residence

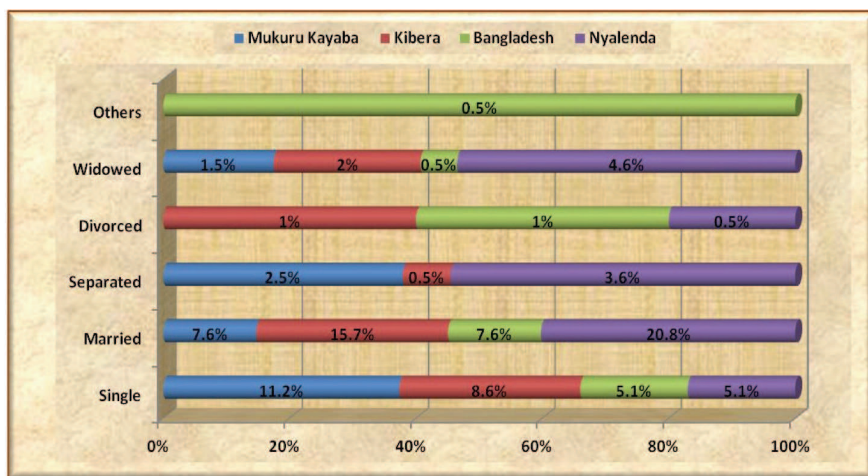


In the same order of location, it was interesting to note that respondents who held degree qualification were so few in slums. For instance Mukuru Kayaba had 4(2.0%) followed by Bangladesh and Nyalenda with 1(0.5%) each respectively. Surprisingly, all of them were young unemployed graduates who had just graduated. This trend may imply that most degree holders relocate to the middle class estates that are a bit secure with better social amenities and improved social conditions after they get jobs even if they were initially living with parents or relatives in the slum as college students or job seekers. Respondents who claimed to have attained other types of qualifications through informal learning and productive skills empowerment initiatives without attaining primary school certificates were distributed as in Bangladesh 2(1.0%) and 1(0.5%) in Mukuru Kayaba. On the basis of this data we conclude that most of the respondents had attained secondary level of education closely followed by those who had graduated in primary school level.

This explains why people chose to live in slums since they could not afford the cost of living in other places due to their meagre income and small business economy found in these localities.

This type of economy makes people live on small quantities of essential items like food, paraffin, charcoal and cooking oil among others.

Figure 5: Distribution of the Respondents Based On Marital Status and Area of Residence



As illustrated in figure 5 above, 22(11.2%) of the respondents in Mukuru Kayaba were single while 17(8.6%) in Kibera and 10(5.1%) in Bangladesh and Nyalenda each respectively were of the same status. Those who were married in Mukuru Kayaba and Bangladesh represented 15(7.6%) each respectively, while in Kibera they were 31(15.7%), and 41(20.8%) in Nyalenda where more stable families were evident. In all the regions only 13(6.6%) of the respondents were separated. The number of widows seemed to be more in Nyalenda at 9(4.6%) compared to Kibera which had 4(2%) and 3(1.5%) in Mukuru Kayaba and 1(0.5%) in Bangladesh in Mombasa. This small percentage of the widows could be explained by the fact that people in slums have had good access to anti-retroviral drugs (ARVs) from the medical clinics which prolongs their lives even when they were living with HIV or AIDS. Similarly, a small number of 5(2.5%) of the respondents in the four study sites claimed to have divorced. This implies that most people preferred to maintain firm marriage values to avoid being infected with HIV or

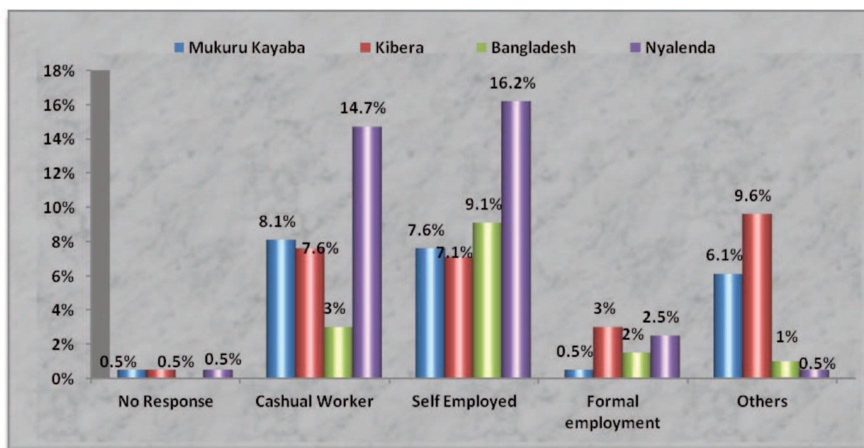
AIDS. Interestingly, 3(1.5%) respondents in Bangladesh affirmed to belong to the gay sexual category. They ascertained that they offered themselves for homosexual sex to earn a living, but not because they were in this sexual orientation. Asked about how many other members of their group there were in Bangladesh, they claimed that there about 11 others, although there could have been others they never knew. In overall they claimed that there were over a hundred and sixty (160) gay people in Mombasa Island alone. They argued that most of their customers were whites, Arabs and a few black Africans who were concentrated at the beaches as the meeting points. Asked about how much they earned per day, they put it between Kshs. 400 and 1000, which is equivalent to (US$ 4 and 10) depending on the customer and day of the week or month.

One of them was asked whether he was married. He however complaint that he was not interested in women. He cited commercial homosexuality as a major survival trick among young men and women in Mombasa. On whether they use protection against HIV and AIDS, they affirmed that it was the responsibility of the other partner to protect himself. Asked whether they would like to engage in a different economic activity other than homosexuality; one of them argued that he used to sell 'madafu' (coconut juice) on the streets before, but the business was not paying enough for his daily needs. '*I can do other things for an income, but my partners would demand that I sexually serve them as well. This is my dilemma you see! They also treat us well; they provide food, beer, miraa and cigarettes.'* Asked why they chose this occupation, they argued that it paid promptly and there are no licenses, rent and other expenses involved because their clients hire accommodation, feed and entertain them in bars.
They nevertheless complaint about police arrest and harass whenever they were found in the streets at night. A few claimed they could bribe the police through cash and/ or sex and get their way out whenever they were caught. "*Unprotected sex pays more. In fact you need only one such customer willing to pay between Kshs. 5,000 and 10,000 (US$ 60 and 120) per night and you can rest for days", argued one gay person".*

Figure 6 below reveals that 40% of the people in all the slums are in self employment as a means of livelihood. The majority of this category accounting for 16.2% were in Nyalenda slum in Kisumu who were engaged on small scale businesses like Kiosks, fish mongering and motorbike and bicycle boda boda transport among others. Those in casual work in industries and construction sites were about 33.4%, while a small number of 8% is in formal employment

mainly working as cleaners in the county Governments. About 17.2% residents in all the slums claimed to be doing other types of occupation like the Jua Kali artisanship, car washes, and manning public vehicles terminus areas. A good number were working as security guards in different places in the city centres.

Figure 6: Distribution of the Respondents Based on Occupation and Area of Residence



In relating to the duration respondents had lived in their respective slums, table 3 above reveals that 46(23.4%) in all the slums had lived there for between 11 and 15 years. Another 45(22.8%) had stayed for 5 to 10 years. Thirty nine (19.8%) had been in slums for less than 5 years. The most interesting was the argument by 18(9.1%) that they have lived in slums for all their lives. Some of the reasons cited for people's choice to live in their respective informal settlements include:- "*affordable rent, cheap food and free life with no disturbances from the police. The only challenge was insecurity for new comers. Others indicated that their jobs were in industrials nearby the slum which was quite convenient for them to walk to and from work*".

On why most people opted to live in the slums even when they could afford accommodation elsewhere, various reasons were cited as follows:-

"....the cost of living is cheaper while in other estates it is too expensive. When one goes to a place like Kenya Re (a Nairobi estate), rent would be 20 times more. Others in this place have also made mad houses which they rent at between Kshs. 500, 1000 and 1200 per month. Once you get used, this is the place to live in. We are actually driven here by poverty. There are also many forms of assistance from NGOs and the Church, which you can't access if you were in middle class residential areas."

Table 3: Distribution of the Respondents according to Duration of Stay in the Slums

Duration (Yrs)		Location				Total
		Mukuru Kayaba	Kibera	Bangladesh	Nyalenda	
No response	*F*	-	-	-	*1*	***1***
	%	-	-	-	0.5	**0.5**
Below 5	*F*	*4*	*10*	*9*	*16*	***39***
	%	2	5.1	4.6	8.1	**19.8**
5 to 10	*F*	*13*	*17*	*4*	*11*	***45***
	%	6.6	8.6	2	5.6	**22.8**
11 to 15	*F*	*7*	*10*	*9*	*20*	***46***
	%	3.6	5.1	4.6	10.2	**23.4**
16 to 20	*F*	*4*	*11*	*4*	*3*	***22***
	%	2	5.6	2	1.5	**11.2**
Above 20	*F*	*14*	*4*	*1*	*7*	***26***
	%	7.1	2	0.5	3.6	**13.2**
Life time	*F*	*3*	*3*	*2*	*10*	***18***
	%	1.5	1.5	1	5.1	**9.1**

The key informants gave a concrete view on why the poor infected or affected by HIV and AIDS chose to live in informal settlements as one of them indicates. *"……in my view, it's due to economic factors which push them to live in slums. Nobody would wish to live in such bad environment unless they are constraint financially or there are other advantages to enjoy in the slum. All people would wish to live in a decent place but if you can't afford costly decent housing, your income level pushes you to where you belong. Likewise, population pressure, cheap food products, hiding from the police especially for drug peddlers and traditional beer brewers would make most of them live in slums."*

On the same issue, a religious leaders with over 18 years experience in running a religious ministry in slums argued:-

"……it is mainly because most people are in search of jobs that they start in the slum. Those who were displaced through post election violence in 2007 came here in Mukuru Kayaba. Once people are here, later, they become trapped with no jobs, no capital to start businesses and lack money to educate their children. That is how the cycle of poverty begins in the slums"

However, despite the belief that majority of the people living in the slums are poor, some wealthy landlords, drug dealers and criminals use the slums as their hideout. As a development officer in Mombasa indicated:-

"…….yes there are those who live in the slums to protect illegal practices or sustain and manage their businesses and shanties (houses) that they rent to the poor. Not all the residents here are poor. Some are here for strategic reasons targeting the poor as a lucrative market for their products especially drugs and traditional brews.

Figure 7: Distribution of the Respondents Based on Tenant-ship

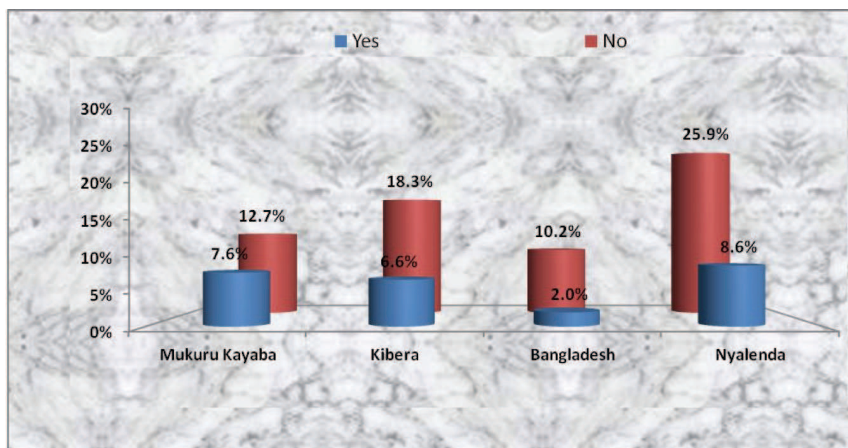


Figure 7 above sort to respond to the question on whether people owned the houses they lived in or they rented them. In all the slums, only 49(24.8%) lived in their own houses. The majority 148(75.1%) had a rented bed sitter.

This implies that there are many wealthy people who benefit from the slum shanties in through rental charges that range been Kshs. 1,000 (US$ 11.8) to 3,500 (US$. 41). Most slum dwellers are tenants. As table 4 below reveals, 126(60%) of the respondents confirmed to be living with between 2 to 5 members of their kin, who mainly used the floor as their sleeping space at nigh since most of the houses were single rooms. About 36(18.3%) who lived alone were mainly single college leavers who were searching for employment.

Table 4: Respondents living with the Next of Kin in their slum houses

Are you living with next of kin		Location				Total
		Mukuru Kayaba	**Kibera**	**Bangladesh**	**Nyalenda**	
No response	Count	14	10	8	3	**35**
	% of Total	7.1	5.1	4.1	1.5	**17.8**
Yes	Count	24	32	15	55	**126**
	% of Total	12.2	16.2	7.6	27.9	**60**
No	Count	7	13	6	10	**36**
	% of Total	3.6	6.6	3	5.1	**18.3**
TOTAL (n)	**Count**	**45**	**55**	**29**	**68**	**197**
	% of Total	**22.8**	**27.9**	**14.7**	**34.5**	**100**

As revealed above, in all the slums under the study 126 (60%) of the slum residents were living with their families. This implies that given the small space and congestion, people have no privacy in the houses.

Responding to the question on how much most of the slum residents earned per month as shown on table 5 below, it was revealed that majority of the respondents were really poor with 59(29.9%) earning bellow 5,000 (US $ 56), which translates to less than US $ 2 per day, yet they have more than five (5) dependants in the family. A higher number of 93(47.2%) were earning between 5,000 and 25,000 (US$ 56 and 280). Surprisingly only 2(1%) respondents from Kibera slum in Nairobi who indicated that they were earning between Kshs. 20,000 and 25,000 (US $ 235 and 280).

As revealed in table 5 below, those whose income levels were above Kshs. 25,000 were 6(3%) and 2(1%) in Mukuru Kayaba and Kibera in Nairobi respectively. There was 1(0.5%)

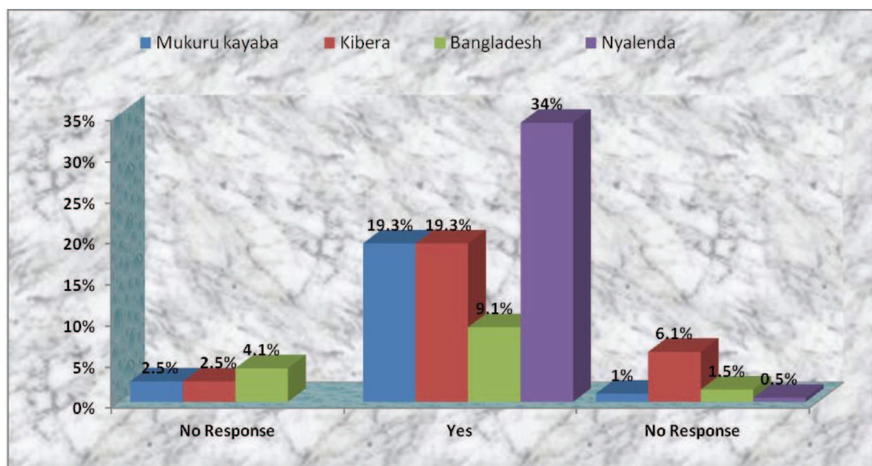
from both Nyalenda and Bangladesh in this income bracket. This is a clear indication that all the slum residents have little income and hence the reason for residing in information settlements. Those affected or infected by HIV and AIDS have to engage on other economic activities to supplement these meagre income. The unemployed people in slums are definitely worse off and their survival tricks are the main concern for this study.

Table 5: Estimated Monthly Income for slum Respondents

Estimates of income in Kenya shillings		**Location**				**Total**
		Mukuru Kayaba	**Kibera**	**Bangladesh**	**Nyalenda**	
No response	Count	7	8	5	3	**23**
	% of Total	3.6	4.1	2.5	1.5	**11.7**
Below 5000	Count	6	8	14	31	**59**
	% of Total	3	4.1	7.1	15.7	**29.9**
5000 to 10,000	Count	12	15	7	23	**57**
	% of Total	6.1	7.6	3.6	11.7	**28.9**
10,000 to 15,000	Count	6	17	2	9	**34**
	% of Total	3	8.6	1	4.6	**17.3**
15,000 to 20,000	Count	8	3	-	1	**12**
	% of Total	4.1	1.5	-	0.5	**6.1**
20,000 to 25,000	Count	-	2	-	-	**2**
	% of Total	-	1.0	-	-	**1.0**
Above 25,000	Count	6	2	1	1	**10**
	% of Total	3	1	0.5	0.5	**5.1**
TOTAL (n)	**Count**	**45**	**55**	**29**	**68**	**197**
	% of Total	**22.8**	**27.9**	**14.7**	**34.5**	**100**

On figure 8 below, it was noted that there were poor people in the slums, 23(19.3%) respondents in Nyalenda and 9(19.3%) in Kibera and Mukuru Kayaba respectively confirmed that slums were the home of the poor since they can not afford the high cost of living in other parts of the city. Asked who the poor were in their own understanding as slum residents, most of them in Mukuru Kayaba described the poor people as "those *who lack education, good jobs, no income at all or are living with HIV and AIDS or orphaned by the scourge"*. In Kiswahili, they described them as "*Walala hoi*" (People who had no shelter and had nothing to eat).

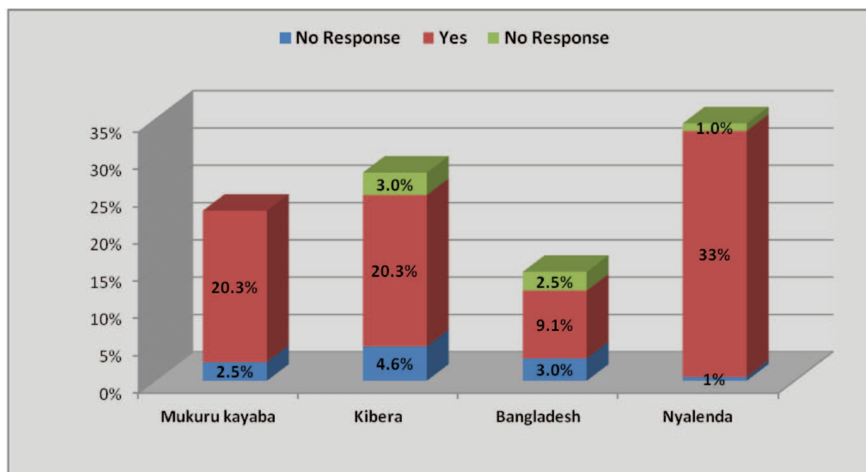
Figure 8: Respondents Perception on whether there were Poor People in slums



In kibera they described the poor as those who are "*disabled, a person who cannot fend for himself or his family, those who lack jobs and have no means of livelihood like small businesses or are not self employed"*. Respondents in Bangladesh in Mombasa described the poor as *"the unemployed, the sickly, the orphaned children, those who dressed poorly because they cannot afford to buy clothes or unreliable income. Those whose standard of living is very low and they have no business or salary. Those with many dependants, those who lack food and are not assured of getting any unless a define miracle happens are indeed poor. They saw those who live in houses made of cartons, polythene papers and sleep on "Magunias"(gunny bags) on*

the streets as extremely poor. *Whereas in* Nyalenda in Kisumu the poor were described as *"those with no income which makes them live in leaking houses, have no power, water and have sewage surrounding their houses*. *They lack food and their children never go to school*. In all the slums, the common categories that were mentioned were the physically disabled who could not work and have nobody to support them. Likewise the elderly who had no relatives to care for them, street families and those who were widowed by HIV and AIDS were seen as poor."

Figure 9: Respondent's Perception on Whether HIV and AIDS Leads to Poverty

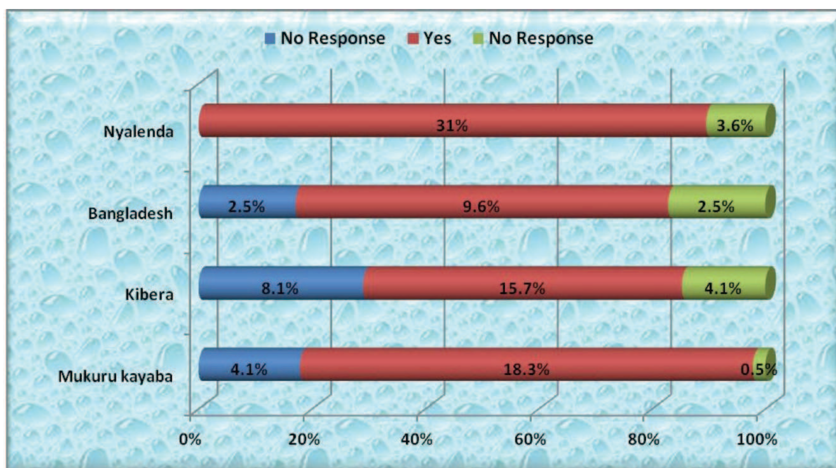


On why they would not consider some people in slum areas to be poor, respondents in Mukuru Kayaba, Kibera and Bangladesh argued that "*the traditional beer brewers who are also landlords and business people at the same time take their children to expensive private schools and universities*. *They own other lucrative businesses like whole sale shops, posho-mills (Maize mills), beer and cigarette distributions, their standard of living is very high compared to that of the other slum dwellers*. *They drive expensive cars*. *These are not poor people but the elites who control all the activities in slums including leadership and church management*. *In fact they are opposed to slum improvement, so that they can continue to exploit the poor*. *Some slums inhabitants lamented that "No Government or NGO staff comes here without going through the elite groups as the representatives of the slum residents*."

Interestingly, 163 (82.7%) of the respondents in all the slums asserted that HIV and AIDS contributes to poverty in the slums. While emphasizing the views of the general residents within the slums, the key informants noted the following issues as being the link between HIV, AIDS and poverty:-

> *"……If I can give an example of Kibera slums, if a household has no food, the girl children or their mother would easily offer sex to get money for household food. In most cases it is unprotected sex. These are desperate means of survival applied by the poor……..Due to poverty, a parent will accept to offer a young daughter of between 14 and 15 years for marriage even when they know the man is infected with HIV and AIDS. They are even aware that the man would dies and leave the child a widow after a few years.*

Figure 10: Respondent's Perception on Whether There Is a Relationship between HIV and AIDS and Poverty



> *HIV and AIDS contribute a lot to the poverty increment in slums. For example, we are three wives in this household and you get that he has infected all of us and we will die, although we are getting free medicine from the Catholic Church health clinic. Our husband claims, we are the ones who infected him. Once all of us are dead, our children will end up in the streets or become robbers since they will have no means of helping*

themselves. This is quite evident here, children who were once very comfortable, become seriously needy once they are orphaned." Asked of the vice versa whether HIV and AIDS also leads to poverty as figure 9 above shows, the same respondents noted that:-

"……Yes, HIV eventually leads to full brown AIDS which is quite expensive to manage. Keeping healthy is expensive. Thus the scourge causes poverty due to high cost of nutritious food stuffs, medicine for opportunistic infections, low returns to work and high level of dependency"

Table 6: Whether Poverty is a Cause of HIV and AIDS among the Youth

Poverty causes HIV and AIDS		**Location**				**Total**
		Mukuru Kayaba	**Kibera**	**Bangladesh**	**Nyalenda**	
No response	Count	6	8	5	1	**20**
	% of Total	3	4.1	2.5	0.5	**10.2**
Do not agree	Count	5	4	4	17	**30**
	% of Total	2.5	2	2.0	8.6	**15.2**
Slightly agree	Count	7	1	-	9	**17**
	% of Total	3.6	0.5	-	4.6	**8.6**
Agree	Count	1	2	3	5	**11**
	% of Total	0.5	1	1.5%	2.5	**5.6**
Averagely agree	Count	7	14	1	20	**42**
	% of Total	3.6	7.1	0.5%	10.2	**21.3**
Strongly agree	Count	19	26	16	16	**77**
	% of Total	9.6	13.2	8.1%	8.1	**39.1**
TOTAL (n)	**Count**	**45**	**55**	**29**	**68**	**197**
	% of Total	22.8	27.9	14.7%	34.5	**100**

Apparently 145(74.6%) of the respondents in all the slum areas confirmed that the HIV and AIDS and poverty are closely related. A person living with HIV and AIDS spends too much on

medicine and food, and likewise a poor person may be infected with the disease as they indulge in risky survival tricks like prostitution. A new dimension emerged in Kisumu ndogo area of Kibera as an elderly respondent gave these sentiments on the link between poverty, HIV and AIDS as indicated on table 6 above:-

Table 7: Respondent's Perception on Whether There Is High Vulnerability to HIV and AIDS in Slums

There is high vulnerability to HIV and AIDS in area		Location				Total
		Mukuru Kayaba	Kibera	Bangladesh	Nyalenda	
No response	Count	8	8	6	2	**24**
	% of Total	4.1	4.1	3	1	**12.2**
Do not agree	Count	5	2	-	-	**7**
	% of Total	2.5	1	-	-	**3.6**
Slightly agree	Count	2	3	2	-	**7**
	% of Total	1	1.5	1	-	**3.6**
Agree	Count	8	1	4	-	**13**
	% of Total	4.1	0.5	2	-	**6.6**
Averagely agree	Count	6	9	3	5	**23**
	% of Total	3	4.6	1.5	2.5	**11.7**
Strongly agree	Count	16	32	14	61	**123**
	% of Total	8.1	16.2	7.1	31	**62.4**
TOTAL (n)	**Count**	**45**	**55**	**29**	**68**	**197**
	% of Total	**22.8**	**27.9**	**14.7**	**34.5**	**100**

> *"....Being HIV positive or living with AIDS here in Kibera is an advantage. Such people get a lot of attention and assistance from NGOs, community Development Fund (CDF) and the Churches around. For that reason, many other people seek for means of being infected so that they can be enrolled among the beneficiaries for free ARVS, food, cooking oil, sugar and wheat flour including school fees for their children. Poverty can*

make people so desperate. It is no longer stigmatizing to be HIV positive, but indeed an opportunity". In our view, if people are now seeking to become HIV positive by choice in order to access assistance, then this could jeopardize the gains made over the years on the fight against HIV and AIDS not only in slums but also in the rest of Kenya. It would also negatively affect the Millennium goal No. 6, on combating HIV and AIDS, malaria and TB by 2015.

Table 8: Whether People With HIV and AIDS Progress to Abject Poverty

People with HIV and AIDS progress to abject poverty		Location				Total
		Mukuru Kayaba	Kibera	Bangladesh	Nyalenda	
No response	Count	6	8	6	3	23
	% of Total	3	4.1	3	1.5	11.7
Do not agree	Count	1	11	1	7	20
	% of Total	0.5	5.6	0.5	3.6	10.2
Slightly agree	Count	7	1	4	9	21
	% of Total	3.6	0.5	2	4.6	10.7
Agree	Count	6	5	4	16	31
	% of Total	3	2.5	2	8.1	15.
Averagely agree	Count	5	7	6	13	31
	% of Total	2.5	3.6	3	6.6	15.7
Strongly agree	Count	20	23	8	20	71
	% of Total	10.2	11.7	4.1	10.2	36
TOTAL (n)	**Count**	**45**	**55**	**29**	**68**	**197**
	% of Total	**22.8**	**27.9**	**14.7**	**34.5**	**100**

The most striking revelation was recorded by a respondent who survives on brewing changaa and mnazi traditional brews in Bangladesh slum in Mombasa when she claimed that:- "*To accelerate the rate at which our brew ferments and increase the alcoholic strength, we buy ARV drugs,*

clash them and mix with the brew. It ferments in a few hours and the beer is super strong after distillation!" This meant that the Government and NGOs that are distributing ARV drugs lost a lot of resources as some beneficiaries' sale the products to traditional brewers. Similar sentiments had been raised in Mukuru Kayaba in Nairobi.

On whether poverty is a cause of HIV and AIDS, 119(60.4%) strongly agreed across the slum areas that poverty influences the level of infections and spread of the scourge as people engage on risky life style behaviours like unprotected sex in search of money. The implication is that the poor are actually at risk of being eliminated by the disease. They bear the highest blunt of the scourge in informal settlements. The general conclusion that could be drawn from the above claim is that on the overall, majority 131(66.5%) of the respondents drawn from the four slums strongly believe that depending on the situation, HIV and AIDS would lead to poverty as reflected on table 6 below.

Poverty exposes people to the disease as well. It was revealed that sustaining a person on good diet if he or she is on ARVs is an expensive responsibility for a slum dweller that lives on meagre income or no reliable sources income at all.

Surprisingly, on whether HIV and AIDS leads to abject poverty, as illustrated below on table 8, a small number of respondents at 71(36%) thought that was the case. This reaction may be associated with the fact that the rich or their dependants may not necessarily become poor since they can manage the effects of the disease and enjoy their full life span, unless they engage on risky practices. The rich have an advantage since they can afford medical care, less strenuous activities and stable diet.

It could be concluded that most of the respondents thought that the poor in their respective areas disregarded protection against HIV and AIDS because it was seen as an opportunity to enable them join those being assisted by the Development agencies.

This was a counter effective reaction since it would increase the rate of new infections by more than 31% in future. As respondents were reporting on the popular community perceptions on HIV and AIDS at Kibera they asseterted that "......*it's no longer a deadly disease as we knew it. This disease is not a threat to one's life as it was a few years ago. To be sincere, we are not afraid to know our status any more. If it was found that I am positive, I will take ARVs, remain health and life goes on as usual. I will be receiving food and other types of assistance from*

NGOs, the church and the Government, unlike those who are not infected. We do not care anymore about it, it has become a normal part of live….".

Table 9: Whether the Poor Disregard Protection against HIV

The poor in this area disregard protection against HIV and AIDS		Location				Total
		Mukuru Kayaba	Kibera	Bangladesh	Nyalenda	
No response	Count	7	9	6	-	**22**
	% of Total	3.6	4.6	3	-	**11.2**
Do not agree	Count	13	6	3	14	**36**
	% of Total	6.6	3	1.5	7.1	**18.3**
Slightly agree	Count	4	3	3	8	**18**
	% of Total	2	1.5	1.5	4.1	**9.1**
Agree	Count	2	7	4	18	**31**
	% of Total	1	3.6	2	9.1	**15.7**
Averagely agree	Count	5	9	1	9	**24**
	% of Total	2.5	4.6	0.5	4.6	**12.2**
Strongly agree	Count	14	21	12	19	**66**
	% of Total	7.1	10.7	6.1	9.6	**33.5**
TOTAL (n)	**Count**	**45**	**55**	**29**	**68**	**197**
	% of Total	**22.8**	**27.9**	**14.7**	**34.5**	**100**

As reflected on whether the poor neglected protection on HIV and AIDS and therefore that is why they die in large numbers than the middle class and the rich, only 66(33.5%) agreed. They claimed that the poor die most because they lack adequate resources to facilitate their diet. The stressful life they live contributes to their poor health and early death.

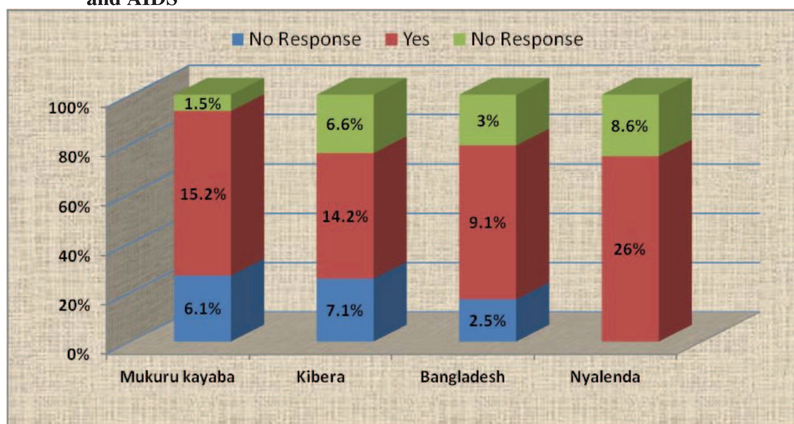
In Bangladesh, a focus group of six respondents reiterated that*; "This disease is just a normal thing now, it's not news anymore. If you call a forum to discuss it nobody will come. They expect nothing new from any presentation".*

In fact, Maleria is more of a threat here in Mombasa. That is why people are silent about HIV. It is so common to us. Only the most ignorant will die of this disease". At Nyalenda in Kisumu, another focus group claimed that*, "this disease is a punishment from God to control*

and reduce immorality in the current generation. That is why it is associated with 'Chira' a curse according to the Luo traditional belief system"

In our opinion, all these views imply that people in slums no longer care about being infected or living with full brown AIDS. This attitude would make most people contract the disease which would lead a disaster in Kenya and the rest of the world where almost everybody would be on ARVs making health care too expensive. At the same time, if the disease is not were managed, most employees in the labour industry would be missing their duty leading to low contribution to the economy.

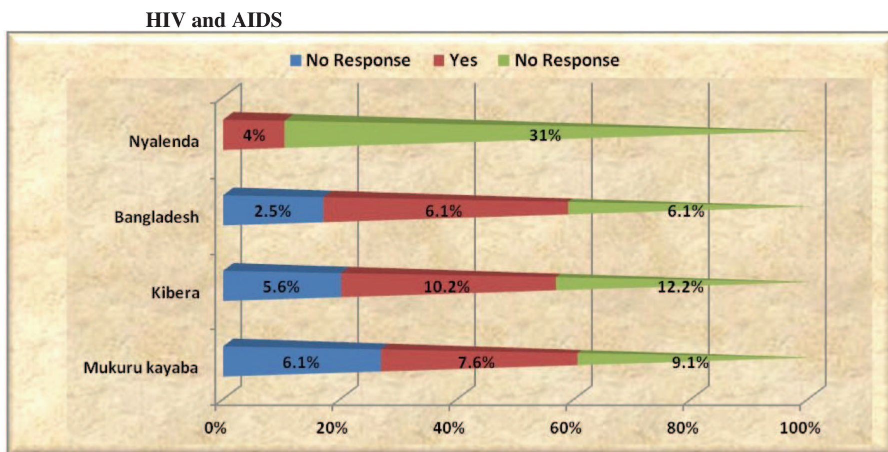
Figure 11: Whether Poverty Levels Have Increased During the Advent of HIV and AIDS



As figure 11 reveals 127(64.5%) of the respondents in all the slums felt that the poverty incidence had increased during the HIV and AIDS advent. Particularly in Kibera which seems to be poorer than all the other slums in terms of poor sanitation, high rate of unemployment, low income levels and high number of children orphaned by HIV and AIDS. However they argued that there is an emergency of many Development agencies claiming to fight the disease including the Government unlike before. However, they argued that making people aware about the disease does not reduce its negative effects on them, but they continue to become poorer each day. Quite often, the work of these organizations is not visible as residents lamented. They do not seem to help transform the lives of the infected and affected as they claim. A concerned

respondent wondered, "*These days there is no natural death. Everyone is presumed to have died of HIV and AIDS related complications unless they had a car accident. We must wake-up and know death is inevitable".*

Figure 12: Existence of Policy Framework on Poverty alongside the Fight against HIV and AIDS



The study further sought to establish the nature of existing policy framework to address the plight of the poor living with HIV and AIDS. As one of the District Development Officer (DDO) summarized on this aspect:-

> *"……..several policy guidelines on safeguarding stigmatization and maintaining equal treatment of all citizens exist. However it does not provide special treatment to the poor neither does it categorize them as a special group. They fall under vulnerable groups of society who are at risk. There are no special guidelines on the poor living with HIV and AIDS, although they are entitled to free ARVs in government dispensaries and religious health facilities. Likewise there is no policy framework for identifying those who are poor as a result of HIV and AIDS and those who are poor due to other factors like unemployment or low economic growth, marginalization and historical injustices among others".*

4.3: Analysis of Targeting procedures and errors in HIV and AIDS programmes

Although targeting procedures needed a longer period to observation and analyse, where food rations were distributed in slums, they were provided to all those who attended the food distribution gathering. In most cases those who were not affected by HIV and AIDS although they were among those who were generally poor due to the fact that they live in a slum, were more than a half of the beneficiaries of food relief. This denotes a F-errors since those who lived with HIV and AIDS and deserved the assistance most were left out. In distribution of ARVs in medical clinics, at least most of those living with HIV and other AIDS related opportunistic diseases were reached. Those who are not living with HIV and AIDS do not associate themselves with ARVs or even want to be seen near VCT centres. This showed high E-errors of between 0 – 25 per cent since none of those who were not living with HIV and AIDS benefited. This intervention was well targeted because only those who were sick requested and used the ARVs. However in Mukuru Kayaba and Bangladesh slums, there were some affected people who sold the ARVs to those who made traditional brews like changaa to use as ethanol. In this case, F-error of 50 – 75 per cent emerged because they used some drugs for their own treatment and sold the rest for cash. The fact that the drugs were put in to none intended use, then the project missed its target and it was partially a failure, leading to corruption and misappropriation of resources.

Those organizations that used cash transfers as a social welfare targeted mainly the elderly people who were 65years and above in slums. This project was the most controversial since some people who were born between 1955 and 1960 got the cash instead of only those who were born in 1948 and earlier. Even then, whether people had HIV and AIDS or not, did not matter. This means that this project realised high targeting F-errors of over 76 per cent since it never put into consideration those living with disease or make an attempt to consider them alongside the other needy people.

In the subsidized informal education and school feeding programme in slums, all the children regardless of whether they were orphaned by HIV and AIDS got lunches and were getting cash donations and materials like books from donors through NGOs like Lea Toto and others. These programmes missed the target by between 50 – 75 per cent since children from non-poor households would go home in the evening and find food, but orphans have nobody to take care

of them. The children from the working class who had a salary benefited as well. The grand-parents who kept some of these orphans are so old that they cannot do any casual jobs. Orphans were therefore found to suffer more due to there vulnerability whenever they were put together with other children as a homogeneous group.

Orphan girls were found to server more than boys because they lacked sanitary towels, body lotions and money for making their hair. This subjected them to sexual exploitation by men to solicit for little money for such dire needs. Grand-parents love their grand children a lot, but they never saw the need for such luxuries like sanitary towels when the children under their care had no food, rent or paraffin for lighting the shanty house. This is confirmed by the following nation by one of them in Nyalenda slums in Kisumu, "Vitu za kujisitiri ni nadra kupata. Kile kidogo ninachopata hutumika kwa chakula, malazi na mafuta taa ya kupikia kwa nyumba" (*The little I get is used for food, rent and paraffin*. *Buying sanitary towels is just not possible within my meagre earnings*)

CHAPTER FIVE

5.0 Findings, Conclusions and Recommendations

This chapter presents a discussion of the findings. It generates some conclusions and Recommendations derived from the findings. It seeks to make some proposals on what needs to be done by various stakeholders in strengthening the coping mechanisms of the poor and reducing the negative impacts of HIV and AIDS on vulnerable groups of society who are already disadvantaged by being poor in society. It helps in ensuring that the gains made already in the fight against HIV and AIDS in Kenya and other parts of the World are not lost.

5.1 Discussion of Findings

a) Means of Livelihood in slum Settlements

As revealed in figure 6, most residents in the slums engage in small scale businesses and casual work for survival. Nyalenda in Kisumu for example had 32 respondents (16.2%) in self employment and 29(14.7%) working as casuals in fish processing and other sectors. In all the slum settlements, 79(40%) were in businesses while 66(33.4%) were casual workers. Those in formal employment constituted only 22(11%). It is evident that once people got higher income, they relocate to more secure and well established residential areas because they can afford higher rent and transport to work. Surprisingly, 34(17.2%) claimed to be in other types of occupation. Asked what these were, 13(6.6%) out of 19 of them from Kibera claimed that they sold traditional brews such as Changaa, Busaa and Kagara, and 6(3.0%) women confirmed that they were in the commercial sex industry, since casual work was not available daily and they had children to take care of all the time.

Generally most of the residents sampled thought that the poverty levels in their respective slums had increased during the period of HIV and AIDS scourge since 1980s. In Bangladesh (Mombasa) respondents argued that "*most breadwinners have died. In fact there are more orphans in this slum than it was the case earlier. This is why most households are headed by single mothers or young orphaned youths"*. A religious leader confirmed these views by observing that:- "*Matangas (funeral fund raising activities) are held every day in this slum. In some days you find up to six such fund raising drives"*. He further claimed that the women and the youth were the most affected groups, although husbands were also dying. He concluded that '*all the groups in the community including children, the sick, and the elderly are greatly affected*

which makes the poverty situation worse. This makes the affected people more reliant on the church for their protection although tribal welfare groups make contributions for burials. Sometimes the people are overwhelmed which drains their social support systems".

b) Sources of Support for People Living with HIV and AIDS in Slums

Some of the agencies mentioned by residents of Mukuru Kayaba as providing assistance to people living with HIV and AIDS included Matter hospital (VCT centre, ARVs, counselling and periodic food rations). Mukuru Promotion Centre (MPC) provides education in both primary and secondary schools at low cost or totally free for orphans. They also provide vocational training for the youth, business investment training and capital building and investment training for widows/ widowers). Sisters of Mercy provide medical and nutritious food stuffs besides running the health clinics. Child Fund supports education through sponsorship in secondary schools and colleges. Mbagathi District hospital has a VCT centre. The Matter Hospital's comprehensive HIV and AIDS care clinic has an outreach section which serves slum residents besides a well established VCT centre and a counselling unit. Zinduka Africa was cited as providing food, counselling and medication; and used clothes to people living with HIV and AIDS and their dependants. The Mary Immaculate clinic (MIC) which is run by the Mukuru Promotion Centre provides affordable treatment, VCT and Nutritional support. They also have an established rehabilitation centre for street boys. Nairobi Remand Prisons Clinic (NRPC) offers free ARVs and TB treatment. Child Fund (CF) and the Sisters of Mercy (SoM) provide schooling facilities and sponsorship for orphaned children in primary, secondary and vocational schools. They promote various Economic Empowerment Projects (EEPs) through Poster Parenting Approach (PPA), particularly to total orphans who are highly vulnerable like girls.

c) Social Development Agencies in the Study Area

Some of the Development agencies in Kibera slum includes Medicines without bounders (MSF), AMREF, Lea Toto and the Catholic Church which provide support and services similar to those offered by agencies in Mukuru Kayaba.

According to the residents of Bangladesh (Mombasa), the area has fewer organizations addressing the plight of PLWHAs. The Catholic Church parish in the area is predominant the main social support provider of health care, besides numerous private clinics run by incompetent

staff; they provide VCT services and ARVs, food, clothing, a school and an advocacy program meant to improve the welfare of the poor affected by the disease.

Another community movement established by the residents "BAMAKO" helps the women to engage in small businesses, home based care, condom distribution and public health education and awareness on HIV and AIDs within the slum. A few other agencies such as Aphia Plus, who assisted young mothers who were HIV positive and APHIA II, which supported HIV and AIDS orphans, had temporarily suspended their services in the area.

Some of the least mentioned agencies working in Bangladesh include Faulu Kenya, Alpha and Omega youth organization, PSI and catholic sisters in Mikindani parish. Agencies mentioned as assisting PLWHAs in Nyalenda include World vision, Tuungane, Pand Pieri, FACES, Concern worldwide and Aphia plus II Nyanza branch.

5.2 Non Governmental Organizations' Intervention

The NGOs were cited alongside Faith Based Groups (FBGs), well wishers and sympathisers as some of the supporters. In Nyalenda in Kisumu, it was reported:-

> *".....If a person is too ill to work, Christ of Hope a religious NGO helps with food stuffs, medicine and school materials. The churches that offer spiritual support alongside the NGO work were cited as the Baptist and Catholic churches. They also offer business loans and investment training and guidance advise*. NGOs mainly focus on advocacy and behaviour change. *Women groups were reported to be working in partnership with NGOs:- "....Kazi Ngumu a women's group works with Aphia Plus, People Living With HIV and AIDS had formed a group here in Nyalenda which works under the Kenya Network of Women living with Aids (KENWA) which is a regional NGO supported by different donors...."*

5.3 Central Government and Country Government Involvement

Despite the availability of the Constituency Development Funds (CDF), it was reported that people have not felt the impact of the central government or the newly established county governments as shared by this respondent;

> *"..... Chiefs and Assistant chiefs distribute bursary forms for school fees; which we fill but are rarely awarded the money. .....but those with HIV and AIDS get full support from*

TOA (Total War against HIV and AIDS). People write proposals and if they qualify, then the group is given money for investment."

While sharing similar opinion in relation to the governments input, one of the district development officers indicated;

"…….We offer capacity building on how people should take care of themselves and their care givers (immediate family member). We would provide basic care kits, which contain malnutrition flour and medical logistics. We have partners who offer support depending on presenting needs, but the challenge is that we rely mainly on partners who provide food supplements that are distributed through the government. Sometimes, donors reach out directly families. In addition, there is spiritual support given by the religious leaders. Clients are supported according to their needs. …………. we diagnose and give drugs and do home visits in partnership with NGOs or CBOs. The Government's main role is coordination of the activities through NACC."

Besides awareness and educational support for the youth, parents are assisted to establish small scale businesses as indicated by one of the respondents below;

"…….when we raised our complains as a church, they agreed to support them as much as they could and according to those we had counselled and agreed to go for ARVs, they bought local goats for them as a social livelihood security measure but some have been stolen and others died. Out of the ten goats, only two have remained."

The assistance is not only limited to HIV positive persons only, but to anybody who is interested. It is therefore evident that other than VCT centres and ARVs treatment, no other development assistance targets PLWHAs more specifically as a vulnerable group.

"….we have Practical Action, a local NGO whose focus is environment protection. They help youth groups with farm implements including seeds, tools and training. Sustainable Environment Community Development (SECD) mobilizes school leavers to do skill training for their survival, to avoid the effects of being idle at home."

5.4 The role of the Donor Agencies

As shared by one of the respondents, most social development programmes in slums in Nairobi are predominantly donor supported with no Government assistance and involvement.

"…….almost all the social empowerment programmes in Nairobi's slums are funded and run by NGOs in partnership with the donor community. In fact in all the slums to be

precise, the ongoing activities are funded by donors through local and regional NGOs in partnership with the community groups. In Kibera example, donors such as Medicines San Frontiers' (MSF), The President's Emergency Programme For Aids Recovery (PEPFAR) supports the Total War on Aids (TOWA) fund. CARE Kenya, AMREF and the Catholic Relief Services (CRS) just to mention a view, are all running projects in this slum. Unfortunately, very few of these agencies target people living with HIV and AIDS as a special category of clients alone"

As noted the government occasionally distributes relief food through the chief's camps to the households, but not in all the villages in the slum.

"…… On the other hand, the government distributes relief food once in a while here at the chief's camp. Beneficiaries are identified and selected by the assistant chiefs and the leaders of the Nyumba kumi initiative (The government's Ten Household partnership initiative). The food rations are too little, which sometimes ends up in the shops, since people need money for other domestic purposes".

During the study, it was established that within Mukuru slums the support parents receive from the Faith Based groups especially Mukuru Promotion Centre and its collaborating partners like Child Fund (CF) play a key role in promoting child growth, health and education as shared by this respondent one of the religious leader:-

".....without the religious group's support, many households would not afford to provide essential meals each day to their school going children. If it were not for our feeding programs, children wouldn't be going to school. Parents take children to school as a way of decreasing household expenditure on food during the day. Children are assured of porridge in the mid morning and lunch which actually motivates most of them to go to school every day. These are indeed vulnerable children. A slight failure to sustain them in school means they would begin collecting garbage on the streets immediately to supplement their parents' meagre income. Feeding programme in schools is therefore a stop gap measure to control most children from getting in to the street life".

For women to raise income in Mukuru Kayaba slums, it was noted that they engage in different activities such as washing clothes for the affluent families in rich neighbourhoods like South "B" and South "C" estates, as one of the women narrates:-

"……several of us converge in South "B" or South "C" to seek for the usual job of washing clothes. You have to be really early if you do not have telephone numbers for your bosses. Sometimes we are unlucky when there is nothing to wash. Some women sell boiled maize by the roadsides especially outside the industries, because the washing clothes is not a guaranteed opportunity."

5.5: Faith Based Organizations

Faith Based Organizations (FBOs) like Mukuru Promotion Centre (MPC) promote self initiatives rather than providing handouts as shared by this respondent

"….another survival mechanism adopted mainly in Mukuru slum is voluntary saving and Loaning (VSL) system among the women and self help groups. Group members come together and make savings on all their contributions every week. The savings are given as a loan to a few members who start repaying back after one month with the agreed interest. After repaying the loan half way, the amount is awarded to another set of members. As the fund grows, it revolves among all the members. After all of them get loans from the first round; a second round begins in order to enhance their investments. The loan is never awarded to solve any domestic household social needs. The programme aims at strengthening the members' income levels to reduce poverty in the long term, create employment and reduce insecurity in the area in the slum.

On matters of health challenges another respondent summarized the information as reflected below:-

"…….the Mater hospital through the comprehensive care clinic that deals with HIV and AIDS complications and nutrition refers the patients who cannot afford to pay for medical services at the hospital to Mary Immaculate Clinic (MIC) and the Industrial Prison clinic subsidized health care services. Catholic Parish in South B also helps the group occasionally with food and clothing.

On how the implications of HIV and AIDS on the poor could be effectively addressed and controlled in the respective areas; respondents in Nyalenda suggested that Development agencies and the Government could focus on "*Addressing food stability, improve the living standards of the poor, ensuring economic stability by availing cheap loans and grants for the poor and*

introducing tough rules on drugs and alcohol which has devastated the youth, and estrange massive campaigns on AIDS" whereas those in Bangladesh at the coastal region, proposed that *"Awareness creation to change the negative attitudes of the youth, avail resources to boost nutritional support and income generating activities were necessary alongside, continuous HIV and AIDS testing and use protection never people had sex with strangers".* Those in Kibera argued that *"there should be adequate drug supply and moral education to the people"* whereas those in Mukuru Kayaba in Nairobi suggested "*provision of ARVs, education and nutritional support as the lasting solution to poverty in the advent of AIDS in slums"*

5.6: Coping Mechanisms of the Poor

In regard to the coping mechanisms of the PLWHAs in their respective slum areas, some respondents mentioned that to avoid discrimination the sick were pretending not to be affected, which increased transmission and stigma. This was assumed to be a better way of avoiding rejection. With regard to infecting others and being re-infected, PLWHAs claimed to be abstaining from sex, while others especially in Bangladesh argued that with ARVs there was no need to worry. What they needed was nutritious food to continue to live healthy.

In dealing with low immune levels, poor health and opportunistic infections, respondents indicated that PLWHAs in their respective slum areas claimed that the ARV treatment was a great relieve. However, low income levels made them extremely desperate since opportunities for raising income were very few. Drugs were also readily available in Government and religious health clinics unlike in the past.

Respondents indicated that affected family members coped with various aspects of HIV and AIDS in different ways. In regard to social support systems, they claimed that the disease created a flat form numerous sources of assistance. In Bangladesh for example they argued that "*We get a lot of support and encouragement from family members. In fact those families that do not have infected members regret a lot as the affected ones get assistance"* One common survival trick cited in Kibera was that family members organised fund raising initiatives called *"harambees" (meaning pulling resource together for collective initiative). The funds were used for for medical bills and funerals".* while those *in Nyalenda* pointed out that affected family members normally provide for each other with weekly support from churches and sympathisers.

One respondent claimed "*HIV and AIDS are now the main funding tools in churches*. *This is how pastors are getting free money disguising it to be for those infected"*.

"Availability of ARV treatment and counselling has greatly made us (those living with HIV and AIDS) comparatively cool and normal, when we eat well and reduce stress, we look even better than the normal people who claim to be HIV free", one young lady asserted.

While sharing on the survival mechanisms of PLWHAs, respondents in Mukuru Kayaba and Kibera in Nairobi indicated that, the young men cited casual jobs, boda boda transport, small businesses, Kazi Kwa Vijana (KKV) (meaning manual casual jobs for the youth) and engaging in robbery as their sources of livelihood. Women on the other hand survived by engaging in small business, selling illegal alcohol and largely doing commercial sex in the evenings to supplement their income. The means of survival for the infected children were cited as; taken them regularly to health clinics for ARV treatment, upkeep by parents, getting sponsorships for education and receiving nutritional supplements from NGOs and the churches.

In Bangladesh, it was reported that some men who were PLWHAs survived by assuming there was no AIDS. Mr. Mutsera (not his name), argued "Hakuna kitu kama ukimwi, ni Wazungu tu wanatupabaisha wapate kazi ya kupanya huku kwetu na pesa" (there is no such a thing like AIDS, it is the white people who are using these claims to get an opportunity to come here and make money). The other people claimed to use condoms and ARVs, doing small businesses, and other claimed to engage in casual jobs at the Mombasa port where they offload and load cargo ships. Young men survived on occasional stealing (whenever other opportunities were not yielding to any money), some youths were selling drugs and women engaged in prostitution at *Jambo Village* where people from Zaire (the present DRC Congo) met. Women who were PLWHAs survived through women groups commonly referred to as '*chamas' (collective groups) such as Bamako, some were* selling illegal brews and drugs which they carried in expensive leather handbags as a cover-up, they engage in beach commercial sex where they target tourists. There are those that rely on God's mercy as well as begging on the streets. The older women sell food stuffs including omena (young fish) along the main street in Bangladesh slum. Some of the infected respondents argued that they use herbal treatment because it is cheaper.

5.7: Survival tricks of Children affected by HIV and AIDS in Slums

Children living with HIV and AIDs survive from well to do families are on ARV therapy. The grandparents who provide care orphaned children are enrolled on the Government cash transfer payments programme where the little cash they earn is spend on food and other domestic needs. The other orphaned children are adopted by relatives and well wishers. Those who have no relatives are pressed in children homes that are run by churches and NGOs.

Respondents from Nyalenda indicated that boys who were living with HIV and AIDS survived by doing fishing on lake Victoria, *Jua-kali casual jobs (commonly referred to as on the hot sun)*. While most of the girls survived by washing clothes, supplying water in households, and few work in saloons shops. Child commercial sex is also an alternative source of living just like it happens in the beaches at the coast. Most children sell roasted peanuts coupled with begging on the main streets. Majority of these children have dropped out of school and have adopted street life style.

Similar question was asked to the key informants to elaborate the survival mechanisms of the poor children living with HIV and AIDS in slums. In Nyalenda as highlighted by one respondent, children engage on all manner of activities to earn a living most of whom are on the influence of drugs as noted below.

> *"……Some children sell traditional brews like chagaa, busaa and bhang (carnabies) as agents of the main adult dealers. This is done since kids are really suspected to be involved in such transactions by the police. Most young women including some school going students engage on commercial sex".*

The family structures and economic factors played out in the survival mechanism within Nyalenda, Kisumu with one of the respondents indicating that:

> *"….Most single mothers do not follow any established family structure. Their children lack moral values and are not entitled to any extended family property inheritance. This practice makes those living with HIV and AIDS comparatively worse off since the extended family resources never reach them.*

5.8: The support Systems and Empowerment Opportunities

The support systems were not only evident in the Nyalenda slums but also in the other areas under the study as shared by this respondent who gave a vivid narration of support groups as essential platforms for mutual support in slums:

"……basically the common mechanism of survival is through social support groups. There are wide networks of People Living with HIV and AIDS (although Women groups are more visible and consistently vibrant). The groups act as social security not only on material wellbeing but also on mutual and therapeutic support".

Similarly the commercial sex industry was identified as a broad source of livelihood in all the slums under the study as a respondent ascertains:

"……you will hear most young girls regret; 'I left the rural areas to come and stay with my cousin as I search for a Kibarua (casual job) here in town. After a while I realized the kind of job she does (my cousin) is commercial sex work. After sometime I was inducted in to what looked like a lucrative source of income from local and foreign tourists at the beaches and hotels. Initially I was quite reluctant to really do this kind of thing. I did not know what to expect from a Man! That is how I was slowly introduced to sex work'. My cousin started complaining that I either look for money for rent and daily upkeep, or I walk but home, because she could not continued feeding a grownup woman like me". These Ladies have endless testimonies why they engage in sex work, even if they have other types of employment. They don't confide their real names for confidentiality reasons though."

While confirming cases of insecurity as a source of survival for some youth within the slums, one of the respondents noted that

"...the grownup school dropout youths, majority of who are idle with families survive on theft and robbery with violence. They sell garbage or work as Matatu touts (min transport) in bus terminus, but when those opportunities are unavailable, stealing is the easier way to earn a living. No slum is secure at least for a person who is not a regular visitor"

In ascertaining the role played by the church and government, another faith based head noted the contributions made by the two as indicated below

".....there is food support provided by the World Food Program (WFP) to the school pupils and is facilitated by the Government of Kenya in informal settlements. In this case the Government is just a facilitator but contributes nothing in form of materials. Children in slum schools are provided with a meal for lunch and the extreme cases in the evening before they go home. The parents make monetary contributions of kshs 300 (US $ 3.3)

per child per term for buying firewood and paying the cook. Suppose a parent has more than one child and has difficulties in raising the money, they can be exempted from paying depending on the context of the situation which is evaluated by the social work office. Households with very needy pupils and the orphans are given a priority for exemption. If a parent is sickly, exemption from paying the money is highly recommended. The church is the greatest and the most reliable source of assistance in slums. They provide family support, relief food, education and healthcare assistance among others".

Besides the WFP School feeding programme, the mainstream churches have their own feeding programmes especially for pre-primary school children and food rations for needy households. While confirming that there is high donor presence in the slums except in Bangladesh in Mombasa, a key informant from the civil society indicated that there are many NGOs in the slums especially within Kibera in Nairobi. All of them claim to assist the poor in the slums in one way or another as summarized below:-

"……there is a heavy presence of NGOs in the Slums for example APHIA plus, The Christian Brothers, Ruben centre and Mukuru Promotion Centre which network and Collaborate with the LEA TOTO programs in Kangemi. All of them work under the coordination of the National AIDS Control Council (NACC). Other agencies include KICOSHEP in Kibera, AMREF, CARE KENYA, SAPTA and UNICEF among many others".

Surprisingly it was observed that women were more active in Nyalenda especially the widows who have set up various Household Social Support Group Initiatives (HSSGIs) as compared to men have had no active group associations. Women who are living with HIV and AIDS have created an enabling atmosphere for learning particularly on management of small scale businesses and facilitation of their local financial and therapeutic services. As a female respondent explains.

"…….Men are reluctant to work together in groups. After they wake up in the morning, they go read newspapers on the streets, except the few who use bicycles, motorbikes and mkokoteni (Handcats) as boda bodas (a common means of transport, which initially used to carry heavy luggage from one countries boundary to other). Another common engagement for men who are widowers is barbers shops (Kinyozi). Majority are just idle

drinking traditional brews, which makes them die faster due to being inactive and poorly fed. In Nyalenda, most Women were busy cooking and selling chapatti, Mandazi, nyoyo, sukuma wiki, Kitheri, beans and Mgongo wazi (borny fish, after filets are removed) by the road sides to support their families.

A good number of women and girls go washing clothes from one house to the next for about Kshs. 150 (US $ 1.8) to 300 (US $ 3.5) depending on the volume of clothes".

While addressing the issue of prostitution, one of the respondents in Bangladesh, Mombasa observed that though poverty may be a contributory factor to commercial sex, HIV is not necessarily a contributing factor to the practice as indicated below. This is because some people claimed that once girls discovered that they were HIV positive, they would engage on commercial sex to spread the disease.

> *"…….the younger women survive on prostitution but I do not think they are driven to the sex industry because they are HIV positive. The difficult socio-economic siruation probably drives them to the activity, just as a survival mechanism. This is actually common in every major town in Kenya."*

Responding to the question on how the poverty associated with HIV and AIDS could be addressed; a number of safety nets were cited such as:- education and technical support for orphans and vulnerable children through the annual central governemnt budgetary allocations. This would empower the children to be self reliant and protect them from drifting into the poverty cycle. Provision of capital and training on business management for the widows and widowers was seen as a viable initiative to make them able to support their families. Scholarships for primary school leavers and college students were cited as a good cushion. Providing ARVs, nutritious food stuffs, cash transfers for the elderly whose children and bread winners have died of the disease, and dimystifying VCT work to help all the people to know their HIV status were seen as urgently necessary to avert new infections. However, we believe ignorance is a major cause of the silence on effects of HIV and AIDS in society. Unfortunately, most people seem to assume the ARV treatment of a total cure of AIDS.

5.9: Meagre Government Support and Donor dependency

Responding to the question on the basic sources of funding in Kenya, the key informants lamented that most of the HIV and AIDS programmes were entirely donor funded. Some of the

key financiers mentioned are the Global Fund, PEPFAR (through USAID) and DFID among others. The low Government allocation of resources towards the fight against HIV and AIDS were a challenge to the accomplishment of the Millennium Development Goals MGDs) and the Kenya's vision 2030. They claim that the health sector is usually allocated good proportion of the budget, but very little is used on addressing the effects of HIV and AIDS on society, since the nature of poverty caused by the disease have never been critically evaluated and determined. Poverty in Kenya is treated as a general term. According to these key respondents, the Government needed to play a greater funding, management and create an empowering role to help in the fight against the detrimental effects of the scourge on society.

Among the youths, one of the youth leaders indicated that:-

> *"…….many youths are parents in this area. For example at 26 I have two kids. Others have up to five children who totally depend on them for upkeep and all the other social support. We can be assisted through mutual groups to establish small scale businesses where the profits would be shared for social protection".*

In addition the respondents proposed the need for recognizing the contribution of community health workers in the slums who do advocacy on the importance of proper ARVs use, domestic care for the sick, family planning and condom use to prevent new HIV infections.

> *"…..Community health workers who work for NGOs need to be supported and motivated. They do a good job since there is no Government presence here in slums."*

In how to empowering the poor and PLWHAs living in the slums; the following short-term, medium and long-term initiatives were proposed:-

> *"…..School feeding programmes for school going children and those in children homes cited as essential. Lunch sessions in church compounds for orphans and medical waivers are important in the short run to reduce such burden from parents. The ministry of education and other Non-governmental agencies could provide uniforms and other learning materials to children including supplementary partial payment of teachers in school and informal learning opportunities for the youth out of school. Training initiatives for technical skills should be the focus for the long-term to enable the youth to be independent and self-reliant in future. Adults ought to engage in agribusinesses since there is ready market for vegetables in slums. The youth could be hired to clean the streets and water channels in the long-term. This would create alternative sources of*

income rather than the traditional brews, drugs and crime. Institutions like pand-pieri in Nyalenda which is an all inclusive rehabilitation centre for morals, skills, and leadership could be replicated in the other slums. Self reliance should be the long term goal in all initiatives".

As shared by one of the NGO staff in Kibera on how needy children are identified and selected in slums:-

".....We have a criteria for identifying and selecting orphaned children and destitute for sponsorship. First there should be undisputable evidence that the family resides here and are well known because there are people who seek help and after a month they are gone. We have to know the children and the schools they attend, where school principals can ascertain that the child has no one to provide for them".

Asked whether there are policies to address poverty increase alongside HIV and AIDS eradication, some respondents were aware that they exist. In Kibera where the highest response was recorded at 6(10.6%) out of 55 respondents, claimed that there were guidelines on safeguarding stigmatization and provision of ARVs in hospitals but it does not distinguish between the rich and the poor, but all are treated the same.

In our view, we can conclude that there is evident that these policies are not knownto the public even to some leaders although the National Aids Control Council (NACC) has published guidelines to regulate different efforts made to a safe the vulnerable groups in society.

On existing policy framework, another key respondent in the health sector noted:- *"……Currently we are guided by the Kenya HIV and AIDs Strategic Plan (KNASP III) 2009/10 – 2013/14 which was established in line with MGDs. This broad plan of action has four guiding pillars".*

Pillar 1: *Health Sector HIV Service Delivery (HSHSD)*

The goal of Pillar 1 is to achieve Universal Access targets for prevention, treatment, care and support services by 2014. The Health Ministry is responsible for achieving this goal through streamlined, consolidated and responsive leadership and governance.

Pillar 2: *Sectoral Mainstreaming of HIV (SMH)*

The goal of this pillar is to integrate HIV prevention, treatment and socio-economic protection interventions in all areas of the public and private sectors, as well as civil society. This involves integrating HIV into the mainstream of development planning, '*including poverty eradication strategies'*, national budget allocations, and sectoral development plans. This pillar '*is concerned with the impact of AIDS'* on productivity and labour costs, companies, employees and their families. The plight of people with special needs, including (Most-at-Risk-Populations (MARPs), people with disability, and the unemployed and vulnerable young people are addressed in this pillar.

Pillar 3: *Community-based HIV Programmes (CBHP)*

This pillar targets Knowledge, demand and utilization of services in the formal health system are highly dependent on a strong community-based advocacy and referral system. Therefore, community-based interventions would ensure that an effective system is in place, including greater capacity of individuals and communities to demand accountability with regard to access to and quality of services. It focuses on the community level to ensure that prevention efforts are differentiated by region/ area and cause of vulnerability. It indents to strengthen community capacity towards achieving universal access and social transformation for an AIDS-aware and competent society.

Pillar 4: *Governance and Strategic Information (GSI)*

Pillar No. 4 outlines strategies to create an enabling environment for implementation of all pillars through strengthened policy, leadership, oversight, partnership, and governance at national and decentralized levels at the Counties, where some of the health functions have been devolved.

Although it is evident that policy framework is in place to address various aspects of HIV and AIDS, Pillar No. 2 is the most relevant to this study in two ways:-

First, it focuses on poverty eradication strategies on the one hand, and on the other hand, it indents to address the impact of HIV and AIDS on different cadres of society. This study

however finds no particular programmes geared towards supporting the household members whose conditions have become worse due to loosing family bread winners to HIV and AIDS or being affected by the disease and losing their means of livelihood like jobs as a result, or children who are orphaned or withdrawn from school/ college because parents have died or have been retired since they are too weak to work. Whenever people become too weak they are terminated from employment or prematurely retired.

> *All these aspects are in line with the MDG No. 1: on* ***Reducing extreme poverty by half by 2015*** *and No. 6; which targets:* ***Combating HIV and AIDS, Maleria and other diseases by 2013.*** *Nevertheless, most of these policies are not known to the public except those who are implementing them at the institutional level". Likewise there are no specific programmes dealing with HIV and AIDS related poverty. In fact there is no framework of indicators to determine the nature of poverty as a result of HIV and AIDS in any literature. Poverty is generally addressed as a universal pandemic. Whether people are poor because they lost a bread winner or because their guardians spend a lot of resources on the management of HIV related ailments, it is all addressed as a case of vulnerability".*

Asked about the coping mechanisms of the PPLWHAs at the neighbourhoods and household levels, several tricks of survival were reported:- In Nyalenda, Kisumu a respondent revealed:-

> *"……Here those of us who are infected or affected by HIV and/or AIDS join the Post Test Welfare Groups (PTWGs). This is because any form of assistance is channelled through these groups. Besides mutual sharing, we support one another psychologically in the groups. We are given food and ARVs through the health centres. Here in pandpieri centre (A religious community training centre run by the archdiocese of Kisumu), we organize home prayer visits and encourage each other to live on and be active. We engage on numerous small scale economic empowerment initiatives that have always bound us together. Some groups buy and sell Omena (small premature fish). Others grow mushrooms; few Women run food kiosks, Majority sale vegetables and some brew changaa and Busaa (local brews) for a living. The youth do car wash, bicycle and motorbike transport (commonly known as bodaboda locally, which engages so many of the youth). Home based care program is our source of life here. Some of our daughters*

who dropped out of school work as house-girls and others do mobile clothes washing from one house to next. We are not aware of any policy guidelines. In fact even if they existed, they can't help us. Before we became united, our friends were dying in large numbers due to isolation, stigma and neglect. Today death is not a threat any more. We are soldering on one day at a time".

5.10: Youth Temporary Engagement Initiatives

The Kazi Kwa Vijana (Casual Youth Engagement Programme (CYEP) which provides manual casual jobs to the youth such as road construction and repairs or tree planting initiatives for daily payment of between Kshs. 200 to 300 was applauded as a good activity that keeps the them busy and out of crime. However, the respondents were not aware of any policies intended to address the poverty associated with HIV and AIDS. Most of them observed that there was no meaningful presence of the Government in slum settlements, although chiefs and assistant chief's offices were there in their midst.

Asked who should implement social policy on HIV and AIDS related poverty, most respondents felt that the Government had the capacity (personnel), logistics (equipment and facilities) and resources (Finances and grants) to effectively do that, but they lack efficiency accountability and transparency as an institution. However, others felt that religious institutions and NGOs were more involved in empowering the poor in slums and therefore any resources channelled through the church and other religious movements would be well managed to reach the most deserving people. To affirm this position, one respondent in Kisumu emphasized:-

"...Pand pieri Training Centre (A luo word meaning 'cover your buttocks') provides counseling training for trainers of trainers (ToTs) and peer educators in schools and villages who help those living with AIDS. The centre assists post-test club (PTC) members to establish small businesses for income generating to the youth. They train them on other technical skills like carpentry, masonry, textile information technology besides life skills to prevent transmission of HIV to one another. It is better placed to address the plight of the poor in partnership with the donors, much better than the governent". In Nairobi, Mukuru promotion centre and Mary Immaculate Rehabilitation Centres were mentioned as potential initiatives through which PPLWHAS could be helped among other Non-governmental agencies.

In Mukuru promotion centre in Nairobi, the youth and widowers benefit from Vocational Skills Loan Facilities (VSLFs) that empower them with business investment and management skills

including accounting and book keeping. They are trained further on Skills, Knowledge, Attitude, Time and Seasoning (SKATS) to guide them in managing their personal life activities. The course helps them to adopt the right attitude towards what one wants to do for their livelihood. They also learn how to adjust their income business activities according to the seasons of the year. If one sales grocery and they are out of season, they can engage on any other fruits that are available in that season. The loans are offered in Chamas (Swahili word for mutual self-help groups). The group members serve as the collateral in guaranteeing each other. They repay the money on weekly basis so that it could be awarded to other members within the group. The money becomes a revolving fund which circulates within the group without being exhausted. After each round, they collectively plan on how the funds would be utilized in the following round. They could choose to keep on enhancing their stocks more and more.

5.11: Life Experiences among the Slum Residents

Our in-depth interview with one of the elderly grandmother in Bangladesh slum in Mombasa reveals what the poor elderly women go through due to poverty which is manifested by HIV and AIDS in slums. We illustrate her life and experience below:-

"Mama Charo (not her real name) is a small groceries and cooked food street vender on the only main street in Bangladesh slum in Mombasa. She has never had her own biological child. She took Charo in her custody (who is now a young married father of three butchery and a M-pesa (mobile phone money transfer trader) after his parents died of AIDS in 1998. Likewise she rescued Aoko (not her real name) a HIV-positive high school student in 2003 from the street after she lost her single mother who was also under the same grandmother's care when she was chronically sick. Luckily for Aoko a local church gave her full sponsorship. The granny who is in her 80s leads a multi-task lifestyle as a result of complex circumstances that are beyond her own making. Due to her caring and loving heart, many young ladies have been leaving their children with her as they go to work during the day, since they cannot afford to hire house-girls. She is commonly known as (shush) meaning grand mum in the area. Her open business shade has become a day care centre that accommodates between three and thirteen children daily. The mothers usually pay for the food (mainly a mixture of maize and beans, locally known as (Githeri) and porridge commonly known as (uji) which their children are fed on while they are at work. Occasionally, some of these relatively young mothers offer the old granny some small token of appreciation. They never pay any formal fees for the child-care services.

At night, other young mothers bring their children for an overnight care at the granny's house as they go for night job shifts in bars, night clubs or twilight commercial sex activities in Mombasa town. This centenarian's mud wall and iron sheet thatched bed-sitter is ever full of different kids (day and night). She says that at least three extra or more children voluntarily come to her in expectation of a cup of porridge or food that her customers do not finish! Her own grand kids (Charo's two sons and a daughter) are also around her all the time.

The children who are left overnight double as her night security and joy since she has people to talk to and send around the house. One night her loosely locked shanty was broken into while she was deeply asleep. The attackers raped her in shifts since she had no cash to offer them, but with children around her, bad people would be scared to attack. Mama Charo's story is a reflection of the painful struggle and the agony the poor elderly women endure in slums in Kenya, especially if they have orphans in their custody.

5.12: Bangla Pesa: A Complementary Currency in Bangladesh Slum - Mombasa

This is a contemporary currency used by members of the Bangladesh Business Network (BBN) in Mombsa. Mama Charo (mentioned earlier) is a member of the Bamako group. This is a group of people whose members are either living with HIV or have lost a family member to the AIDS pandemic. They are united in self-help initiatives that are designed to improve their socio-economic welfare. As a local business woman she has registered her business with the network among other 200 traders in Bangladesh slums. In this new business concept, a cohort of traders use Bangla-pesa, a complementary currency introduced by Koru-Kenya a local Development agency as a substitute for the national currency for local transactions among members. These are temporary vouchers of different denominations that are used in exchange of goods and services just the same way normal legal tender is used to purchase goods and services. The vouchers which have not been formally legalized for use as real money are not a replacement of the Kenya shilling. The money was introduced as a social security stop-gap measure. It intends to benefit small scale business investors in Bangladesh slum as:-

- A unit of credit that provides a means of payment for goods and service that is complementary to official money
- It is therefore presumed to help stabilize the community in the face of monetary volatility where members of the network could trade with each other without use of the expensive national currency

- The locally available credit is made to cushion the community efforts in development projects and a stimulus to business growth and expansion
- It is an effective way of sustaining the value of cash against the ever changing exchange rates and unavailability of cash at the local level.

To our surprise even probably unknown to the other members of BBN and Koru-Kenya, Mama Charo revealed several other benefits that she would get if Bangla-pesa was fully authorized for circulation among members by the central bank and the Government. She asserts that this currency is like a God send to save her life from perennial thugs and rapists. "*The vouchers would protect (us) single women from being attacked and raped at night and all our business money being stolen*". Other than the usual benefits, the money would:-

- Enable easy transactions and exchange of goods and services among members.
- Create an alternative cash that is not attractive or useful to thugs since they can't transact or exchange the vouchers for real Kenyan currency unless they are members of BBN
- It is a source of security to the women. They can easily access goods and services from the network for their businesses.

However, in our view the problem remains, on how the vouchers are converted in to Kenya shillings, unless there is local clearing house where the members of BBN buy the Bangla-pesa vouchers using real legal tender currency, so that if one was to transact with unregistered trader or customer, they can easily change their money in one form or the other? This would protect them from loosing business and purchasing essential products and services that their colleagues in the BBN cannot provide. It is also not clear how these vouchers are protected from fraud since members can easily print and use unauthorized papers in pretence that they were the official bangle-pesa. What security marks, serials and features protect these vouchers from being reproduced by unauthorized people is a challenge.

5.13: Conclusions

The study had initially targeted 250 respondents, however the researcher managed to access 197, out of whom 102(51.8%) were males compared to 95(48.2%) females. This was almost on a 50:50 gender ratio basis although males were slightly more available for in-depth interviews. This may be explained by the fact that most women were busy in casual jobs or attending to customers in their businesses during the day. This trend was different in Nyalenda in Kisumu,

where more women 40(23.3%) to males 28(14.2%) were reached. This is associated with the higher number of widows who participate in organized group initiatives as their source of livelihood in Nyalenda slums. On the basis of these findings, the study makes the following conclusions:-

- There was a general consensus with 175(89%) out of all the 197 respondents to confirm that they chose to live in slums because of the prohibitive cost of living in the middle and the upper class residential areas. Besides rent, food stuffs are readily available on the streets. There is less government presence and police disturbances, making slum areas ideal for illegal enterprises.
- Many NGOs and religious organizations offer assistance for those living with HIV and AIDS in slums unlike in other high class residential areas. These included ARVs, nutritional food supplements, free or subsidized health cares services, education in informal schools, vocational training centres for the youth (Mukuru promotion centres for example) among others as highlighted by 79(40.1%) respondents.
- They cited low cost of living compared to affluent residential areas that are more preferred by the non poor urban residents.
- It was revealed that in slums the poor enjoy cheaper accommodation, food stuffs, second hand products like clothes, cheaper or free informal community schools that are run by the civil society.
- The '*kadogo economy'* (where most products are sold in small quantities like sugar, cooking oil, maize flour are measured with a glass or a spoon according to what one can afford to pay for. This was cited as an influencing factor). This makes the cost of living much more bearable. On the basis of this revelation, it can be concluded that the poor are driven in to the slums by extreme desperation and poverty.
- Informal settlements were also preferred as hide-outs for illegal activities like brewing of illicit alcohol, drug packaging and distribution and mercenary cartels like members of the Mombasa Republican Council (MRC), a group which is seeking to ceased from the mainstream system of Governance of Kenya.
- Most slums are just a walking distance to the industrial estates were the poor find daily casual jobs and others sell cooked foods to casual workers.

- On slum resident's level of education, it was revealed that 158(80.4%) were primary and secondary school leavers. The reason for this trend could be explained by fact that diploma and degree holders tend to relocate from slum settlements to more secure affluent residential areas once their income levels improve after they are employed. Besides, primary and secondary certificate holders usually earn low incomes that can only make them live in a preferably low cost area.
- The few rich and middle class people who live in slums are landlords and traders as confirmed by 156(79%) of the respondents.
- Due to extreme poverty, Men living with HIV and AIDS, especially those who were sacked or can not be employed due to expected loss of work-man hours engage on homosexual commercial sex as revealed by 13(6.6%) in Bangladesh, Mombasa. This is a sign of desperation. The challenge could be widely spread within the slums especially in Mombasa among drug users.
- The gay people claimed to have a network of more than 120 members on the island town of Mombasa alone. They cited offering homosexual commercial sex as an easier and well paying enterprise than other economic activities they had attempted earlier.
- They argued that they were not homosexuals by sexual orientation, but they offered themselves for sex to earn a living since they had lost one or both parents to AIDS or were infected with HIV and they had no alternative means of livelihood.
- In all the three slums under the study, only a small number of respondents 32(16.2%) were on formal employment were they earned a salary every month.
- Ninety eight (49.7%) were casual workers while 67(34%) were small scale traders. A few 15(7.6%) were hawking their items on streets in town. They argued that it was impossible to raise enough capital to begin a stable small scale business. It is therefore evident that most slum residents are not in formal employment.
- A whooping 158(80.2%) of the respondents had lived in the slums for over ten years. Thirty Seven (18.9%) had lived in rental units in the slum for over 25 years. This implies that there are meagre resources in the slum which makes it impossible for the residents to improve their lives and move to higher income levels. The more they continue living in the slum the more life continues to be tougher, making their situation remain the same!

- The worse hit are those orphaned or live with HIV and AIDS since they require special diet to sustain healthy bodies and reduce the bad side effects of the perennial ARV drugs they take daily.
- It was confirmed by 26(1.3%) of the respondents in Kibera were selling the ARVs to traditional beer brewers which are used as ethanol to make (busaa) a traditional beer ferment much faster. These are desperate survival tricks that make people take ricks to earn a living.
- It was found that there are no policy guidelines targeting those who are infected or affected by HIV and AIDS. They are categorized the same as the other poor. This means that AIDS orphans for example have no special programmes of education, scholarships or support systems to help them cope with the impact of the disease.
- The study reveals that as many as 152(77.2%) respondents earn about Kshs. 255 (US$ 3) on a good day.
- While 59(29.9%) confirmed that they earned Kshs. 180 (US$ 2) a day which is not consistently guaranteed except when casual opportunities arise in construction sites or manufacturing industries. These are people who have a household size of between 5 and 7 members. This implies that they have to seek for external support from NGOs and religious institutions to meet their household needs.
- All these issues reflect how the poor living who are affected by HIV and AIDS in slums are excluded from the rest of the society by the fact that they are victims of this disease.
- The study interestingly found that more than a half of the respondents 126(60%) lived with their family members in the slum. Majority claimed that the situation in slums was better than living in rural areas, since social amenities like informal schools and cheap private medical centres were available unlike rural areas where a medical dispensary is found at about 30kms away.
- They argued that for those with children, education was cheaper in informal schools run by NGOs or private investors like Mukuru promotion centre for examples or other religious institutions.
- It was claimed that in slums women are actively involved in selling vegetables, saloon shops and cooked food to supplement their husbands' income unlike in rural areas where they would earn nothing in cash.

- The youth also work on construction sites, car wash points, motorbike or bicycle boda boda (transport services) to earn a living for themselves and their families. Although these were not the best sources of income, at least the youth were earning a living
- Crime (stealing, mugging and breaking in to people houses) was cited a one of the common means of survival by the youth, when alternative sources of income were not available.
- It was argued that 78(39.6%) of the girls especially under age school going children were known to be experienced commercial sex workers in the evenings to supplement their parents support.
- The older women played multi task roles as bread winners of orphans, business people and day or night baby care providers as young women went to work at night or day.
- There is little or no presence of the government officials, security agents in the slums. Assistant chief camps are almost empty and their role is usually less felt, except in settling disputes.
- Likewise, the government offered very little if anything to the poor in slums. Once in a while assistant chiefs provide relief food to a small number of people, but it is mainly religious programmes and NGOs that assist the poor.
- On whether there were poor people in slums, 168(85.3%) unanimously agreed that there were poor people in slums, otherwise no one would choose to live in such a poor and insecure environment if they could afford a better life style elsewhere.
- It was argued that only the landlords were wealthy. That is why they had build homes in affluent estates except those, whose dealings were not genuine and have to hide in the slums.
- Whether there is high vulnerability to HIV and AIDS in slums, a small number of respondents 61(31%) supported the argument. This is because people in slums also protect themselves from HIV infections though not as much as those in high class settlements do.
- On whether HIV and AIDS led to poverty, most respondents 163(82.7%) concurred with the statement. Orphans, widows and those with chronic AIDS related illnesses spend a lot of resources on treatment and protection of those who are left behind. The HIV, AIDS

and poverty are highly related, since deaths breed to orphans who lack basic sources of social support.

- On whether people with HIV and/ or AIDS progress to poverty, only 71(36%) believed it was the case. It was argued that there are people who are infected by the virus or the disease but they are not poor. Others have some viable means of survival which protects them from degenerating in to poverty.
- Shockingly, On whether the disease is a threat to humanity 66(33.5%) argued that "*HIV and AIDS were no longer a threat, but a advantage since those infected were receiving attention and material support from the Government and other donors, unlike the so called uninfected people*. *Besides ARVs protect people and they can live a full life in good health"*.
- Seventy seven (36%) of the respondents strongly believe that people with HIV and AIDS eventually progress to abject poverty due to high level of expenditure on nurturing themselves from the effects of the disease. Poverty likewise was felt to be partly a cause of HIV and AIDS if people engaged in risky sexual behaviour whether they were poor or wealthy.
- On whether poverty has increase during the HIV and AIDS advent, 127(64.5%) of the respondents strongly agreed, although, national figures showed a decline in infection rate. Most respondents argued that although there were fewer AIDS related deaths because of ARV use, high awareness level on use of nutritious foods and less psychological trauma since most people have accepted to live with HIV and /or AIDS; poverty has increased since the first AIDS case in 1982 because those resources that would have been invested in improving peoples' lives and the socioeconomic infrastructure are mainly spent in managing those who are living with HIV and AIDS.
- It is evident that the three decades of HIV and AIDS have just been lost with little meaningful development activity and focus as state governments and international organizations concentrated on averting the scourge and saving human lives, where a lot of resources have been spent in an emergency like process.

5.14: Recommendations

On the basis of these conclusions, the study makes the following recommendations to specific stakeholders in society:-

a) To The National Government

- Since people opt to settle in slums because of poverty, those living with HIV and/or AIDS are even poorer and more vulnerable to socio-economic shocks and political manipulation. There is need for a policy framework enacted by parliament and the senate to declare all those affected by the disease as special vulnerable group that needs special support and empowerment by all stakeholders, but not to cluster them together with the other poor in society where they are not clearly identified for social economic support.
- The study found that there is very little involvement and participation of the National Government in slums although chiefs offices and camps exist. The state and particularly the county governments should set aside resources to exclusively target people living with HIV and AIDS in slums and initiate capacity building by designing special education and technical training programmes to provide them with vocational, business investment and entrepreneurial skills, management and accounting techniques. The state cannot adequately feed a people, but members of the society would feed themselves and their dependants if they were well empowered.
- Avail a special revolving investment fund (RIF) accessible to this special category, not just a Youth or Women Fund; where those affected by HIV and AIDS could invest in any business of their choice and refund the funds with little interest margin of between 2% - 4% to cater for the inflation rate. This would create permanent sources of income and make them self reliant and lift them above the poverty line and desperation. This would be genuine empowerment and support since the fund would be self sustaining.
- There is need for the central government to establish and strengthen youth capacity building for self employment such as Kazi Kwa Vijana (KKV) (youth empowerment jobs) to fully engage the youth and shun the current behaviour where youths are left idle in markets which makes them susceptible to drug abuse (especially alcohol, miraa and mukuka (a vegetation shrub whose leaves are used as a stimulant just like miraa). Idleness and free life exposes the youth to crime as a means of survival.

b) To the County Governments

- The County Governments should set up vibrant offices with staff in different slum centres under their jurisdiction and provide (*salaried*) Regular Security Services (RSSs) including a streamlined and reformed community policing and vigilante

community groups (VCGs)(with monthly financial tokens of appreciation) to demystify the popular belief and notion that there is anarchy in slums were clandestine groups of criminals solicit for payment to protect residents and their property. The Nyumba Kumi Initiative (NKI) may not help in provision of concrete slum security and social order.

- The relevant county ministries of health, education and special programmes should ensure that there is adequate nutritional support to PLWHAs under the partnership with Faith Based Organizations (FBOs), NGOs and the private sector public partnership arrangements. This should target particularly the children living with HIV and AIDS and those from the poor households in slum settlements as a safety-net measure, where potential beneficiaries are strictly identified and selected by the public.
- The newly initiated National Uwezo Development Fund (NUDF) launched by the president in November 2013 could have a proportion set aside for those affected by HIV and AIDS. As it is structured now, it targets the youth and women regardless of their health status and other social challenges affecting them. It is therefore not any different from the former poverty alleviation initiatives run by the government.
- Just like the government has created a Special Social Welfare Fund (SSWF) for the elderly who are 65years and above who receive monthly cash transfer, they could ensure that there is monetary support for those infected with HIV and AIDS especially the young people to enable them acquire the basic food stuffs and pay for their education, training and guarantee them employment through an affirmative action to support their other siblings and safe them from the poverty cycle trap.
- There is need for the County government to enact law to proportionately redistribute the number of NGOs and other support Institutions in slums. Some slums (Kibera and Mukuru Kayaba) in Nairobi and Nyalenda in Kisumu have more NGOs and donor support than the other slums. Bangladesh has only the Catholic parish running the Health clinic, VCT centre and Primary school and relief services among very few other agencies.

c) Non-Governmental Organizations (NGOs)

- NGOs should establish good targeting methods to avoid excluding those living with HIV and AIDS in intervention programmes.

- Faith Based Organizations (FBOs), Non-Governmental Development Organizations (NGDOs) in partnership with private banks could target creation of employment opportunities through affirmative action targeting those living with HIV and AIDS or orphans at a certain percentage like 25% of all new employment opportunities to enable them to provide for themselves. This move would reduce the current dependence on external support by the extended family, NGOs and the government on relief and hand-outs.
- The current silence on HIV and AIDS campaign in Kenya and the region is worrying. There is need to provide continuous education and awareness on using protection, communication and the devastating effects of the scourge which have not changed. People continue to die of AIDS related diseases, but the state and other actors seem to be quiet about the situation.
- There is urgent need to identify those who are engaging on risky survival practices like gay relationships, child prostitution (in beaches at the coast and other regions) drug dealer curtails in slums, brewing of illicit traditional alcohol that use ARVs to ferment; to educate and expose them to alternative sources of livelihood through the Business Investment Funds Schemes (BIFS) and Social Welfare Support Systems (SWSSs).

d) Slum Residents

- Slum residents should change their attitude and focus on self empowerment skill based initiatives. People should aim at transforming their lives by strengthening their small businesses through Small Scale Business Loan Facilities (SSBLFs) that are readily availed in Micro Financial Facilities (MFFs) like Faulu Kenya, Women Development Trust Bank, Waumini SACCO and Bank and K-Ref Bank among others.
- They should take advantage of the government "Uwezo Fund)" (Enabling facility) to expand their businesses and establish legally acceptable alcohol brewing small factories and Refined Water Refilling Plants (RWRPs) to avoid engaging on illegal businesses.
- There is urgent need to seek for home-grown programmes to sustain the HIV and AIDS activities in order to reduce the effects of the disease on the poor. The current arrangement where the funding ratio is 85:15 donor government or donor NGO sharing should change due to the diminishing funds globally. The National and County governments collect all the local revenue and taxes. They should have moral

responsibility to protect and empower those affected by HIV and AIDS in all their survival activities to reduce dependency on donor and government support by allocating a higher proportion of the budget of about 20% on the health sector in order to address HIV and AIDS poverty related programmes at the house hold level.

- Slum residents should be awarded title deeds as security of tenure to enable them invest and develop their plots without fear for demolition of their houses. This would mean that the necessary infrastructural facilities like road network, safe drinking water, electricity, security lights, and sanitation and sewage systems would be installed. This would make slum houses better habitable living units once people do not fear inevitable eviction. This would transform the livelihoods of the poor living with HIV and AIDS in slum settlements.

e) People living with HIV and AIDS (PLWHA)

- The older women who do multi-task chores in slums such as small retail businesses, selling water, cooked food, washing clothes, day and night baby care and neighbourhood leaders especially in churches need to be paid by those whom they serve. Counties should pay them allowances as local village elders for their own survival since they have many orphans who depend on them. It should be noted that County governments collect taxes in all slum businesses and therefore they could give back by reinvesting in empowerment of the poor in the same localities.
- It is evident that unless the impact of HIV and AIDS on society is seriously addressed in development planning and resource distribution, especially cushioning those who become suddenly helpless after their parents/ guardians die of AIDS, Kenya and the region will continue to be extremely poor and vulnerable to minor social shocks like further infections and transmission of the disease, famine and other national or manmade calamities.

f) The General Public

- Those affected by HIV and AIDS live in the midst of the rest of the members of society. They need mutual support and understanding. Open discrimination and ridicule worsens their conditions. There is need to co-exist amicably with them and support them in all their daily activities regardless of what they do for their livelihood.

- Children, teachers and schools officials should support AIDS orphans to accord them good learning atmosphere like the other children in schools and colleges. They should be allocated bursaries, education loans and other learning and training support with the aim of making them excel in their learning as a safe measure.
- Traders should not take advantage of those on ARVs by buying the drugs to use as ethanol in traditional brews. Law enforcers should act on the members of the public who engage on such immoral activities.

References

Abdulla. A et al.: *Towards Sustainable Vulnerability Reduction for Kenya's Ultra-Poor living in Urban Slums*. International Conference: "Social Protection for Social Justice" IDS, 2011. 13 –15

Adolfo Figueroa (2012) Social Exclusion and Social Welfare: in www.aunt.sue.info (Accessed April 16, 2012)

Amnesty International.: *Insecurity and indignity women's experiences in the slums of Nairobi, Kenya*. London: Amnesty International publications, 2010.

Amuyunzu-nyamongo. M et al.: *Putting on a brave face: the experiences of women living with HIV and AIDS in informal settlements of Nairobi, Kenya*. (Online). (Cited on http://www.ncbi.nlm.nih.gov/pubmed/17364385 (Accessed June 24, 2013)

Amuyunzu-nyamongo, et al: *Sexual privacy and early sexual debut in Nairobi informal settlements*. Community, Work and Family Vol. 9, No. 2, May 2006, pp. 143_ 158 ISSN 1366-8803 print/ISSN 1469-3615. 10.1080/13668800600586936. London: Taylor & Francis. (Accessed October, 28, 2013)

Aubre .d.: *Community based sanitation entrepreneurship in Mukuru and Korogocho informal settlement*. Water, sanitation and hygiene: sustainable development and multisectoral approaches. 34th WEDC International Conference, Addis Ababa, Ethiopia, 2009.

Avert. *Funding for the HIV and AIDS Epidemic*. (Online Available on http://www.avert.org/aids-funding.htm. (Accessed October 20, 2013).

Bahemuka, Nganda and Nzioka, Poverty Revised: An analysis and strategies towards poverty Eradication in Kenya, Ruaraka Printing Press, Nairobi, Kenya. 2002

Barry, R and Le Grand (2004) the effects of Economic Social Exclusion on Human Growth, www.adb.org/document (Accessed September 9, 2011)

CACE, Gender, Development and Power; Some Issues and Methods for gender trainers, West Cape, Cape Town, 2010, 46-61

CACE, Equitable Development for All, Western Cape, Private Bag X17, 7535, Cape Town, Southern Africa. 2011, 23-45

Canadian Council for International Co-operation, Two Halves make a whole, Balancing Gender relation in Development, A handbook for Gender and Development training, Canadian Council for International Cooperation, 2010.

Canadian International Development Agency (2008), The Why and How of Gender-Sensitive Indicators: A Handbook for Gender sensitive indicators, drawn from CIDA, and Beck, T and Morton Stelcer (2004).

Centre on housing rights and evictions. *Violations of women's housing rights in kenya's slum communities.* COHRE: 2008.

Daswani, M et al, (2009) (eds) Participatory Training for Women, Society for participatory Research in Asia, 125, Sainik Farm, Khanpur, New Delhi – 110062.

Journal of Acquired Immune Deficiency Syndromes 2014

Kabeer, Naila et al, (2011) Reserved Realities: Gender Hierarchies in Development Thought, Verso, London.

Kenya AIDS Indicator Survey (KAIS), Vol. 1, 2014

Kimanga D. O et al. (2014) Prevalence and Incidence of HIV infections, trends and risk Factors among persons aged 15-64 years in Kenya: Results from Nationally Representative Study. Online edition DOI:

10.1097/QAI.0000000000000124, 2014.
McDonald, Mandy (2010) HIV/Aids and Gender Planning in Development Agencies: Meeting the Challenge, Oxfam UK/I.
Mumbi, Rose. J (2008) HIV/Aids and Traditional Perceptions in Western Kenya, Unpublished MA Thesis, Daystar University
NASCOP (00, 01,02,05,08,09). AIDS in Kenya: Background, Projections, Impact and Interventions: Series of Surveillance Reports for the year 2009 Nairobi, Kenya.
NASCOP (2006). AIDS in Kenya: Background, Projections, Impact and Interventions: Surveillance report for the year 2006. Nairobi.
Nduba, J. (2008) Sexually transmitted diseases case management study in Kisumu. District. AMREF, Nairobi.
Rene' Lenoir (2005(a) and 2006(b)), Social Exclusion: A function of patriarchy dominance, Dioff Publishers Ltd, Lyon, France
Rugalema. G. (2004) AIDS and rural livelihoods: A case study of smallholder households of Bukoba district, Tanzania. PhD Thesis, Institute of Social Studies, The Hague.
Rugalema. G, (2008) HIV/AIDS and the Commercial Agricultural Sector of Kenya: Impact, Vulnerability, Susceptibility and coping strategies.
Directorate of personnel management.: *Public sector workplace policy on HIV and AIDS*. Nairobi: 2005. 54-82
Erulkar.A.S-Matheka. J.K.: *Adolescence in the Kibera Slums of Nairobi, Kenya*. Nairobi: The Population Council, 2007.
Foster. G.: *Under the radar: Community safety nets for AIDS-affected households in sub-Saharan Africa*. AIDS Care, 2007; 19(Supplement 1): S54_S63. London: Taylor & Francis, 2007.
Frank. O. M, R. Vazquez- A: *HIV/AIDS Knowledge and Behaviour: Have Information Campaigns Reduced HIV Infection? The Case of Kenya*. Oxford: Blackwell Publishing Ltd, 2009.
Ganesh. P.: *Models for understanding social problems in slum*. International journal on world peace vol. XXII NO. 2 JUNE 2005*, 59-75*.
Hickman.V.: *Alternative approaches to sustainable slum upgrading in Kenya: The influence of water &sanitation infrastructure improvements on stakeholder perception of well being*. Centre for sustainable development, Engineering department, Cambridge University. PhD research.n.d.
Igaba.W. K., J. Makau: *An Inventory of the Slums in Nairobi*. Nairobi: Matrix consultants, 1998.
International Monetary Fund.: *Kenya: Poverty Reduction Strategy Paper,* IMF Country Report No. 05/11.Washington D.C: World bank publications, 2005.
James-Wilson. D et al.: *Economic Strengthening for Vulnerable Children Principles of Program Design and Technical Recommendations for Effective Field Interventions*. USAID-AED &Save the children :Field report No.2, 2008
Justus.B.W.: *Churches Fighting AIDS in Kenya*. (Online).(Cited on Friday , 17th February 2012).Available on http://www.onislam.net/english/health-and-science/faith-and-the-sciences/416295.html (Accessed May 12, 2013
Kabiru et al.: *Transition into first sex among adolescents in slum and non-slum*

communities in Nairobi, Kenya. Journal of Youth Studies Vol. 13, No. 4, August 2010, 453_471, 2010.London: Taylor & Francis.

Kiragu. J. W.: *Leadership challenges in strengthening national legal instruments and frameworks to address the consequences of HIV/AIDS from a gender perspective*. *In*

Gender and HIV/AIDS: Leadership roles in social mobilization .Report of the UNFPA-Organized breakout panel African development forum Addis Ababa, Ethiopia, 2000. 3-4

Klopp.J.M.: *Remembering the Destruction of Muoroto: Slum Demolitions, Land and Democratisation in Kenya*. African Studies, Taylor & Francis Ltd, London, 2008.

Ministry of State for Planning, National Development and Vision 2030.: *Vision 2030, First Medium Term Plan, 2008 – 2012*. Nairobi: Government printer, 2010.

Muvengi, D. M.: *Poverty, church, and development in Kenya: A case study of Kibera slums in Nairobi*. Thesis Submitted for the Degree Doctor of Philosophy (Missiology) at the Faculty of Theology of the North West University, 2011.

National Aids Control Council (NACC).: *Kenya National AIDS Strategic Plan 2009/10 – 2012/13 (KNASP III)*. Nairobi: Government printer, 2009.

National Aids Control Council (NACC): *National HIV/AIDS monitoring and evaluation framework*. Nairobi: Government printer, 2005.

National Assembly Official Report (HANSARD).: *Creation of scheme to give financial assistance to the elderly,* Wednesday, 27th April, 2011.

Ndwiga Gikiri.: *An exploration of the effects of Male disempowerment on family unity .A case study of Nairobi south Sub location, Makadara district, unpublished masters' thesis*, 2012.

Ngunjiri.F.W.: *Spirituality and Leadership in Action: Women Leaders Fighting HIV/AIDS in Kenya*. (Online) Available on http://theotherjournal.com/2005/08/08/spirituality-and-leadership-in-action-women-leaders-fighting-hivaids-in-kenya/ (Accessed February 17, 2012).

Njoroge et al.: *Female sex workers, FSWs, AIDS orphans multi prolonged problem in Kenya: A case study,2008*, XII p

Okello-Agina, N.D.: *Comprehensive Care for People Living with HIV/AIDS (PLHA)*. Eastern African regional workshop on AAU HIV/AID toolkit role of head of health unit care & support of PLWHAs, 2010

Ohito. D, *Death toll in pipeline fire now 120*: In the Standard. (Online). (Accessed April 20, 2012). Available on http://www.standardmedia.co.ke/relationship/InsidePage.php?id=2000042661&cid=4

Otiso.K.M: *Forced evictions in Kenyan cities*. *Singapore Journal of Tropical Geography*, 23(3), 2002, 252-267*,* 2002, Blackwell Publishers Ltd.

Oxfam G.B.: *Urban Poverty and Vulnerability*. *In Kenya Background analysis for the preparation of an Oxfam GB Urban Programme focused on Nairobi, 2009*.

Russell. S, *The economic burden of illness for households in developing countries: a review of studies focusing on malaria, tuberculosis, and human immunodeficiency virus/acquired immunodeficiency syndrome*. *ed*. J. Trop. Med. Hyg., 71 (Suppl 2), 2004, pp. 147–155, - Published by the American Society of Tropical Medicine and Hygiene

Talukdar.G, D-Potter, C, *Inside Informality: Poverty, Jobs, Housing, and Services in Nairobi's Informal Settlements*. World Bank report, 2006

The Canadian Tuberculosis Committee (CTC), *Housing conditions that serve as risk factors for tuberculosis infection and disease:* (Online).(Accessed February 18, 2012) Available on http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/07vol33/acs-09/index-eng.php

Unge. C, et al, Reasons *for unsatisfactory acceptance of antiretroviral treatment in the urban Kibera slum, Kenya*. AIDS Care, February 2008; 20(2): 146_149pp.London: Taylor & Francis.

UNDP Enhanced Security Unit, *Kenya Natural Disaster Profile*: 2010 (c)

Waithaka, J. K, F. Anyona, F. A. Koori, *Ageing and poverty in Kenya country report for the regional workshop on ageing and poverty in sub-Saharan Africa*. Presented in Dar es salaam Tanzania On 29th – 31st October 2003.

Werlin. H: *The Slums of Nairobi: Explaining Urban Misery*. World Affairs, Vol. 169, No. 1 (Summer 2006), pp. 39-48 Published by World Affairs Institute. Stable URL: http://www.jstor.org/stable/ 20672752 (Accessed September 26, 2013)

APPENDIXES

APPENDIX I

Questionnaire I: ***For people infected or affected by HIV and AIDS in selected slum settlements in Kenya***

Introduction:

The study on "***HIV and AIDS: the Coping mechanisms of the Poor in Kenyan Slums*" *An analysis of the targeting procedures in safety-net programmes"*** aims at attaining a PhD qualification in St. Elizabeth University of Health and Social Work in Slovakia. In this regard we request the contribution of slum residents and other potential respondents in order to generate insights based on actual life experiences from slum settlements. We wish to thank you in advance for your contribution and precious time. Yours Faithfully, Urbanus M. Ndolo:

In case of any *further comments and issues of concern please contact:* undolo@cuea.edu or (+254-721-643-129)

Section A: **Demographic Information**

Q1. a) Gender: M ( ) F ( )

b) Age – group: 15 – 19 ( ), 20 – 24 ( ) 25 – 29 ( ) 30 – 34 ( ) 35 - 39 ( ), 40+ ( )

c) Education Level: Pri ( ), Sec ( ), Dip ( ), Degree ( ) Others: specify ....

d) Marital Status: Single ( ), Married ( ), Separated ( ), Divorced ( ), widowed ( ), Others: specify ....

e) Occupation: Casual worker ( ), self employed: specify ( ), Formal employment: specify ( ), Others: specify...................................

Section B: Social Economic Livelihood conditions

Q2. For how long have you been living here? ....Q3. Why did you choose to live in this area? .... Do you own your house? Yes ---------------------- No -------------

If no how much do you pay for rent? --

Q4. Do you have dependants? A) Yes ( ), No ( ). If yes, how many are your next of kin?

--- Others: --

Q5. Do you live with them (dependants) here? Yes ( ), No ( ).

If yes what challenges do you encounter?

....

If no, why are you not living with them?

....

Q6. a) How would you estimate your income per month? a) < 5,000 ( ), 5,000 - >10,000 ( ), 10,000 - > 15,000 ( ), 5,000 - >20,000 ( ), 20, 0 00 - >25,000 ( ), < 25,000 ( ), If above all these, specify range ( )

b) If in business what is your working capital?_______________________________________

Q7. In you view, are there poor people in this area? Yes..........., No..........If yes, how would you describe them?

If No, why would you say some people in this slum are not poor?

Q8. a) What are the causes of poverty in this slum?

....---

----

b) In your view, who are the poor?---

----

d) In your view, why do you think people live in this area?

Section C: Poverty, HIV and AIDS

Q9. a) In your view, what is the link between HIV and AIDS and poverty?

____

----

b) Are there ways in which HIV and AIDS may lead to poverty? a) Yes ( ) b) No ( ). If yes, please explain how it happens. --

----

c) In your view is there any relationship between HIV and AIDS, and poverty? Yes ( ), No ( )

d) If yes, what is the relationship? ---

If no, give reasons:

----

10. In your opinion, how is Poverty related to HIV and AIDS in this area? Use the following choices to rank your responses, where; **5** show the highest relationship and **1** denotes the lowest. **5** Strongly agree, **4** averagely agree, **3** agreed, **2** slightly agreed, **1** not agreed

The relationship between Poverty, HIV and AIDS in area	**5**	**4**	**3**	**2**	**1**
There is high vulnerability to HIV and AIDS in area?					
Is poverty a cause of HIV and AIDS?					
Does HIV and AIDS cause poverty?					
Poverty exposes people to HIV and AIDS					
The poor engage in risky practices that leads to HIV and AIDS					
People with HIV and AIDS progress to abject poverty					
The poor in this area disregard protection against HIV and AIDS					

Q11. How do people in this slum perceive HIV and AIDS?

Q12. In your view, has poverty level increased during the advent of HIV and AIDS pandemic?

a) Yes (   ) b)   No (   ), If yes, why ____

If No, give reasons ____

Q13. a) In your view, which groups of people are mostly affected by HIV and AIDS related poverty in slums?

----

b) Which agencies provide assistance to the poor people living with HIV and AIDS (PLWHAs) in this area?

Agency	**Nature of assistance**	**Targeting procedure**	**Beneficiaries**	**Length of Programme**

c) How can the implications of HIV and AIDS on the poor be effectively addressed and controlled in this area?____

Section C: Copping Mechanisms of the PLWHA in this area

Q14. a) How are the PLWHA cope in terms of the following aspects:-

Aspect(s)	Coping Mechanisms	
	HIV	**AIDS**
Being rejected		
Infecting others		
Being re-infected		
Opportunistic infections		
Low immune levels/ Poor health		
Stigma/ Anxiety		
Drug supplies		
High cost of living		

13. b) How do the affected family members cope in terms of:-

i) Support systems --

ii) Stigma/ fear ---

iii) Infections --

iv) Perception from neighbours ---

v) Relationship with the infected --

vi) Relationship with the public ---

Q14. What survival means are PLWHA use in this categories?

Categories of people	Survival Mechanisms for the poor infected with:-	
	HIV	**AIDS**

Men		
Women		
Youth		
Children		

Q15. Are there safety net programmes to strengthen these survival mechanisms, and if yes, by whom?

Nature of safety net programmes	Targeted beneficiaries	Main activities	Financing and facilitating agencies

Q16. a) Do you know any policy framework that addresses poverty issues alongside the fight against HIV and AIDS? a) Yes (   ) b) No (   ). If yes, how is its performance? Is it effective?

---

c) In your view, which policies need to be put in place to enhance poverty reduction in HIV and AIDS programmes?

---

d) In your opinion, who should implement these policies?

___

___

e) Please feel free to provide any other information ___

Thank you for your time and insights!

APPENDIX II

Key Informants discussion Guide

Introduction:

The study on "***HIV and AIDS; the Coping mechanisms of the Poor in Kenyan Slums*" *An analysis of the targeting procedures in safety-net programmes'*** aims at attaining a PhD qualification in Social Work in St. Elizabeth University of Health and Social Work in Slovakia. In this regard we request the contribution of selected key informants in order to generate insights based on actual life experiences from professionals in slum settlements. We wish to thank you in advance for your contribution and precious time. Yours Faithfully, Urbanus M. Ndolo.

In case of any *further comments and issues of concern please contact:* undolo@cuea.edu or (+254-721-643-129)

Section A: Demographic Information

Gender:

Age group: 30 – 34 ( ), 35 – 39 ( ), 40+ ( )

Marital status: ____

Qualification: ____

Occupation: ____

Section B: Discussion Issues

Q1. For how long have you been working in this area? __________________________

Q2. In your view, why do people live in slums in Kenya?

Q3. What are the survival mechanisms of the poor living with HIV and AIDS in slums?

Q4. What kind of assistance do people living with HIV and AIDS get in this area and from whom?

Q5. What is the link between HIV and AIDS and poverty?

Q6. What could be done to transform the lives of the poor living in slums today and by whom?

Q7. What targeting criteria are used is selecting the poor for assistance in slums?

Q8. Are there policies that protect PLWHA in this area?

Q9. How are these policies implemented and by whom?

Q10. According to you, which policies could be established to further protect these people?

Q11. Are there initiatives in place to help the PLWHA by whom?

Q12. How can the challenges facing the PLWHA in this area be resolved?

Q13. b) Which agencies provide assistance to the poor people living with HIV and AIDS (PLWHAs) in this area?

Agency	**Nature of assistance**	**Targeting procedure**	**Beneficiaries**	**Length of Programme**

Q14. a) How are the PLWHA cope in terms of the following aspects:-

Aspect(s)	**Coping Mechanisms**	
	HIV	**AIDS**
Being rejected		
Infecting others		
Being re-infected		
Opportunistic infections		
Low immune levels/ Poor health		
Stigma/ Anxiety		
Drug supplies		
High cost of living		

Q15. Are there safety net programmes to strengthen these survival mechanisms, and if yes, by whom?

Nature of safety net programmes	**Targeted beneficiaries**	**Main activities**	**Financing and facilitating agencies**

Kindly provide any other information you might have on these issues.
____

Thank you for your time and contribution!

Appendix III
Focus Group Discussion Guide

Introduction

This study on "**HIV and AIDS: the coping Mechanisms of the Poor in the Kenya Slums:" Analysis of the Targeting Procedures in Safety-net Programmes,** aims at attaining a PhD in Social Work at St. Elizabeth University of Health and Social Work in Slovakia. We there request you to voluntarily share on any issues relating to this topic. Your time and contribution would be highly appreciated.

Yours Faithfully,

Urbanus M. Ndolo, Tel. 0721-643-129 email: undolo@cuea.edu

Composition of the Group: M ( ), F ( )

1. In your view why do people live in slums in Kenya?
2. In your opinion are the people who live in slums poor or otherwise? Please give reasons.
3. In your opinion how are people in slums affected by HIV and AIDS?
4. Precisely, what are the effects of HIV and AIDS on different residents in slums?
5. What methods of survival do people infected or affected by HIV and AIDS use to cope with their situation?
6. What type of assistance do people who live with or are affected by HIV and AIDS get here in slums?
7. Who provided this assistance and how often?
8. How do those who are not getting assistance manage their situation?
9. What policies on HIV and/ or poverty reduction do you know?
10. Are these policies if any applied in the slums?
11. In your view do those infected and affected by HIV and AIDS need any assistance?
12. If yes why and if no, would you please give reason and highlight the nature of assistance they require.

Thank you for your time and fruitful sharing!

Appendix IV
Study Declaimer

Dear Participant,
This study on "***HIV and AIDS: the Coping Mechanisms of the Poor in Kenyan Slums: Analysis of the Targeting Procedures in Safety-net Interventions***" is an academic work intended to attain a PhD degree in Social Work at the St. Elizabeth University of Health Sciences and Social Work in Slovakia. It aims at collecting insights on *'The survival mechanisms of poor who are living with HIV and AIDS or have been affected in one way or the other in slums in Kenya and examine how they are targeted for support in intervention programmes*'. The findings shall not be used for any commercial purposes except for creating knowledge and influencing policy at different levels of society.

The researcher shall not collect and test blood samples to determine the HIV and/or AIDS status of any respondent involved in this study at all. It is therefore expected that respondents would voluntarily and willingly provide information for this noble cause and shall not expect any commercial gain at any level of the study or after its completion. The researcher would respect the will/ wish of any respondent that choose to reveal or not reveal his/her HIV and/or AIDS status. All the information collected would be treated with utmost confidentiality within the mandate and scope of this study. The study does not therefore subject any participant/ respondent to any form of health or psychological risk.

Yours Faithfully,

Urbanus Mwinzi Ndolo, BA (Social Work), MA (Local and Regional Development)
The Researcher

Appendix V

Respondents Voluntary Consent Form

I, ………………………………………………………… (Name optional). (Herein referred to as the respondent) declare that I shall willingly and voluntarily provide information within the stated mandate and scope of this study. I shall not claim compensation or any form of commercial gain for the opinions/ insights I provide for this study. I fully understand the aims, scope, expected outcomes and purpose for this study.

I therefore authorize the researcher to reveal my name, image and or health status if necessary in his report.

…………………………………………………………… **Date:** ……………………….

(**Respondent's Signature**)

NB: If you are not willing to reveal your identity, just sign both places. Your name is not Mandatory in this study.

Potential Areas for Further Research

On the basis of our interaction with people who have been infected and/ or affected by the HIV and AIDS in the last four decades, we have identifies grey areas that would in our view be ideal for further research, such as:-

- *An analysis of the effects of various HIV and AIDS coping mechanism adopted by the poor in Slums* (For example how does sale of ARVs by those who take them affect them individually, affect those who use them to fasten the fermentation process of traditional brews, the donor who freely donated them to safe and prolong life etc)
- *An exploration of the various coping mechanisms on Children in Slums*
- *The detrimental effects of the coping mechanism on child birth and development* eg. Use of the condom and child birth etc
- *A Comparative analysis of the HIV and AIDS Coping mechanisms of the poor in slums and elsewhere in the country side*.
- *The Impact, of the HIV and AIDS coping mechanisms of the poor on the family stability*
- *The Implications of HIV and AIDS Coping Mechanisms of the poor on Social Security*
- *The nature and effects of dependency of HIV and AIDS related poverty on household income levels*

Appendix VI

Plate 1: Housing Structures and Living Conditions in Kibera Slums

Source: Adopted from Google Maps 2018

A view of the housing units and the narrow streets and a garbage dump site. It is evident that only the very poor who are desperate would choose to live in this kind of environment. Most of the paper bags contain human waste that is thrown through the windows.

Appendix VII

Plate 2: The Health Risks Innocent Children Take to Cope with basic Needs in Kibera Slums

Source: Adopted from Google Maps 2018

These two innocent children take sewage water to quench their thirsty on their way home from school in Kibera slums. It is indeed a healthy risk which exposes them to water borne diseases and other infections. However in the absence of an alternative, they have no choose but help themselves.

Appendix VIII

Plate 3: Note the School Pit Latrine and Shanties elected on the River Bank

Source: Adopted from Google Geo Maps, 2018

It is evident that most poor people in slums live in quite risky environments. The house at right fore front has 7 members and it hangs on the main stream which over floods during the rain season. See the school latrine whose waste is channelled to the stream as well. Sometimes the water is used for domestic purposes.

Appendix IX

Plate 4: Human Pit Latrine Exhauster by a Young Widower in Mukuru Kayaba Slums

Source: Google Gachie Blog Com, 2018

Exhausting human waste using bear hands and cooping the waste directly from a pit latrine is a common practice. It is transported by use of a hand cart to the nearby valley. For each trip they earn about Kshs. 500/- (Euro 3.5). This is a common engagement of the Youth in most slums in Kenya especially in Kibera.

Appendix X

Plate 5: A charcoal Seller, One of the common Means of Survival in Mukuru Slums

Source: Google Maps, 2018

Charcoal is the main source of energy in slums since most residents can not afford gas or electricity. Muya (Not his real name) lost his first wife in 2010 and survives on this trade as his main source of livelihood to support his seven children and a new wife.

Appendix XI

Plate 6: An informal School and Orphanage Feeding Programme in Mukuru Kayaba

Source: Google Geo Maps, 2018

Most orphaned children in slums are fed through school feeding programme. The food is donated by USAID and UNDP programmes. Mukuru Promotion Centre does the same programme. This is the main survival mechanism of the children. Teachers supervise the feeding programme.

Appendix XII

Plate 7: Fuata Nyayo Market in Mukuru Kayaba

Source: Google Gachie Blog, 2018

Most widows support their families through sale of vegetables and cooking of food stuffs by the road sites where venders by as they walk. Many mothers here have lost their husbands to HIV and AIDS. Kids live with their mothers at their business places.

Appendix XIII

Plate 8: Boda Boda School Transport by a Youth in Nyalenda Slums Kisumu

Source: Google Maps, 2018

Boda Boda (Meaning from (Boundary to the other boundary), is a means of transport that began at the bonder between Kenya and Uganda. Now it is widely used in Kenya. However in Nyalenda Slums in Kisumu, young Men are hired by parents to transport Kids to and back from school, where they over-load their bikes to carry more children and hence earn more per trip. Each child pays Kshs. 40/- per day (Euro 0.30)

Appendix XIV

Plate 9: Youth from Nyalenda Slums Wash Cars in Lake Victoria

Source: Google Geo Maps, 2018

Youth from Nyalenda Slums work in washing cars at the shows of Lake Victoria as a source of Income. They have to be registered to work there. The water is infected with Bilharzias where most of them are infected in the course of their work. This disease pre-exposes them to HIV and AIDS. In a good day one earns about Kshs. 750 (Euro 6) after payment of country council tax.

Appendix XV

Plate 10: Some of the Orphaned Youth sell water in households to earn a living

Source: Google Maps, 2018

Some of the youth whose parents have passed on distribute water in households and business premises in Nyalenda to earn a living. One 25 Ltr tin sells at Kshs. 15/- (Euro 0.12). In a good day they will make 6 trips making a total of Kshs. 1,080/- (Euro 9). Most of the money goes to traditional brews and *miraa* chewing.

Appendix XVI

Plate 11: Members of the Bangladesh Business Network Launch *Bangla-Pesa* 2012

Source: Google, 2015

In Bangladesh Slums Mombasa, an association of street venders established a complementary currency used in trade and businesses among the Bangladesh Business Network members. Initially they had been arrested before the currency was approved by the Government to be used among the members of the network in the slum.

Appendix XVII

Plate 12: A street vender selling *Samosas* (home made cookies) for *Bangla-Pesa*

Source: Google, 2018

A young street vender sale *Samosas* and other home made cookies for *Bangla-Pesa*. The currency is commonly used by the members of the Bangladesh Business Network (BBN). Here most people who are affected or infected by HIV and AIDS have joined the network as means of survival since they are small scale investors in the slum.

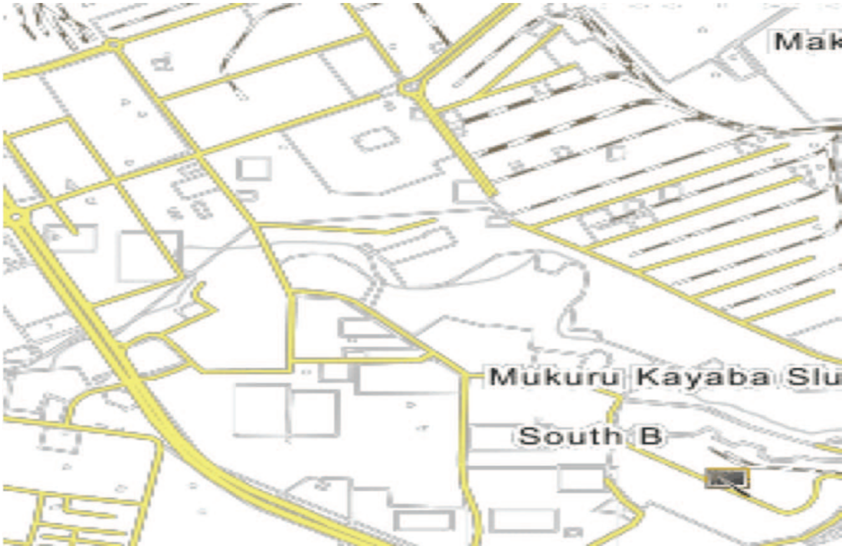
Appendix XVIII

Plate 13: A Map of Kibera Slums

Source: Adopted from Google Maps, 2018

Appendix XIX

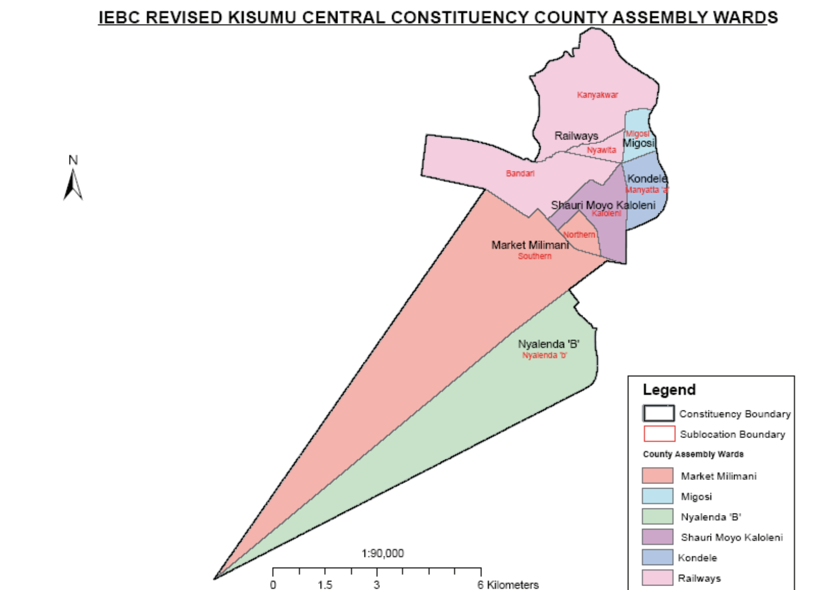
Plate 14: A Map of Mukuru Kayaba Slums



Source: Google Maps, 2018

Appendix XX

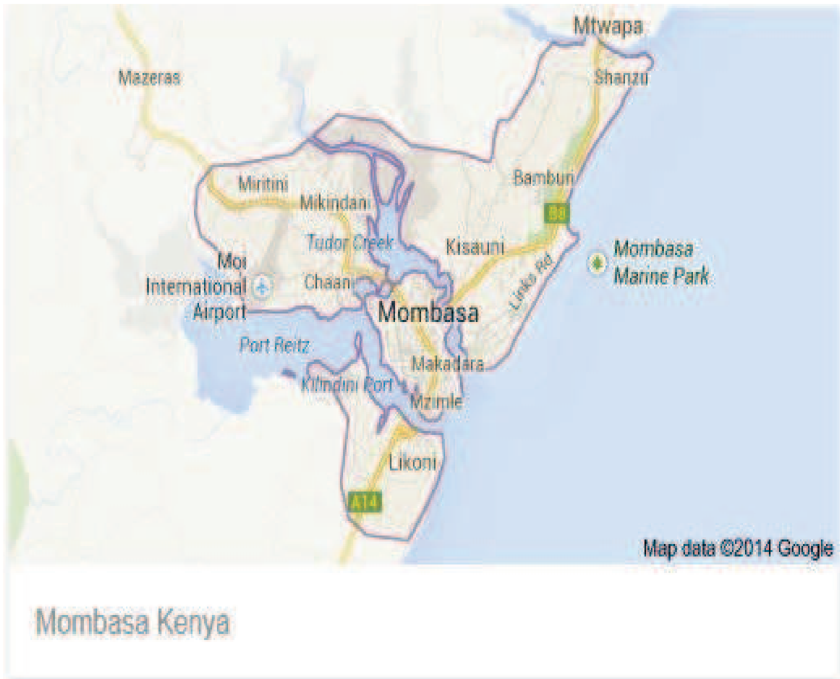
Plate 15: A Map of Country Assembly Wards of Nyalenda Slums in Kisumu



Source: Google Map, 2018

Appendix XXI

Plate 16: Map of Mombasa where Bangladesh Slums are situated



Source: Google Maps, 2018

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