JRIIE Journal of Research Innovation and Implications in Education
ISSN: 2520-7504

HIV and AIDS Silence: The Coping Mechanism of the Youth in Poor Households in Kenyan Slums

Urbanus Mwinzi Ndollo, PhD[*1]

[1]Social Work Coordinator, Catholic University of Eastern Africa, Kenya
***Corresponding author:** umndolo@gmail.com

Received March 5, 2018; Revised April 4, 2018; Accepted April 11, 2018

Abstract: *There is no doubt it is all silent! HIV and AIDS are no longer the threatening health diseases that dominated the local and international daily news! Are HIV and AIDS no longer imminent health challenges, particularly among the youth in slums in the contemporary World today? The paper explores the critical implications of this silence yet no cure seems to be on the table yet! Why are funding allocations and the vibrancy that used to be there diminishing yet people are still dying in the midst of little support and international attention? A recent study on the coping mechanisms of the poor in Slum settlements in Kenya revealed that while it was a death sentence to be HIV positive or be living with full brown AIDS, apparently people are intentionally exposing themselves as a strategy to qualify for socioeconomic support safety nets! The study adopted a mixed research design with both qualitative and quantitative perspectives predominantly applied. Out of the 136 females and 89 males, structured observation and interviews, with key informants and focus group discussions were employed in data collection. The Statistical Package for Social Sciences (SPSS) was used to analyze quantitative data, while qualitative data was analyzed and processed through key themes emerging from the respondents. The paper concludes that once the trend becomes an alarming challenge since life is back to normal with safe sex being a none material concern at the Global arena, the stakeholders are likely to revive funding sources and renew their strategy on protection projects, which would be too late to salvage the devastation the scourge will have imposed on society. Definitely the water will have spilled! Apparently there is need to restructure the HIV and AIDS policy framework and revive mutual collaborative support to save the innocent citizenry in whose view, the danger is out of hand and sex is seen as a free social good for mutual interaction and appreciation of human co-existence.*

Key words: HIV, AIDS, Silence, Cure, Youth, Coping, mechanisms, slum settlements, safety, nets

1. Introduction

The study set out to investigate how the youth (18-39 years) in poor households in slums cope with the effects of HIV and AIDS, since the world is now silent about the scourge. The United Nation's, Sustainable Development Goals (SDGs), (UN, Org, 2015) and state governments put these disease under goal No. 3, on health and well being agenda. Does this mean that humanity is free from this disease to day? In particular are the youth in Kenya safe from the scourge? Prior to the advent of HIV and AIDS in early 1980s, Kenya had chronic levels of poverty at above 48% since independence (Bahemuka, Nganda and Nzioka, 2004). To-date, there is little empirical findings on the impact of HIV and AIDS and the coping mechanisms of the youth in the poor households in the Kenyan slums, and how they are targeted in safety net programmes. The survival tricks adopted by the youth affected by HIV and AIDS which includes intake of Anti-retroviral Drugs (ARVs), seeking help from churches, NGOs and well wishes and how the social protection intervention initiatives target and influence 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, 2017). As National AIDS and Sexually Transmitted Control Programme (NASCOP, 2016) indicates, this drastic decline may be associated with positive changes in behaviour among the youth who are a high risk group, condom use among them since most of them fear pregnancy, not because of contracting sexually transmitted diseases; and high intake of ARVs

and treatment for the infected young people, whose status is already known, since in most countries such drugs are provided for free. 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 Anti retroviral treatment has been a core intervention in hospitals and health clinics. There has been improved diagnostic, treatment and prevention of sexually transmitted diseases (STDs) among all age groups. Promotion of policy and advocacy activities; and undertaking both social and pure scientific research on the management of HIV and AIDS has been highly improved (NACC, 2017). However, despite all these efforts, HIV and AIDS related deaths continue to rise among married couples, more specifically in Nyanza, the Rift valley, Coastal and Eastern regions of Kenya (UNAIDS, 2016). Although the national prevalence has declined from 7.2% in 2007 to 5.6% in 2014, and to 4.3% in 2016 as cited by Volberrding P. A & Blattner W. A (2017) world Aids progress report, the current poverty headcount ration of about 45.9%, estimated at 15.5 million rural and 3.3% urban poor in Kenya continues to rise. In slums poverty exceeds 53.1% (WFP, 2015). How much of these figures are contributed by HIV and AIDS complications and deaths especially among the youth is not known which informed the need for this study. The nature of poverty caused by HIV and AIDS on the young people is still a gray area that we committed the study to explore.

2. Review of Literature and Empirical Studies

2.1 An overview of HIV and AIDS in Kenyan Slums

Generally people are quiet about HIV and AIDS in Kenya. One would assume the disease is not a health threat anymore! In fact people have gone back to their old free sexual interaction behavior. Although several measures and enormous resources have been invested on the fight against the 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, 2016). As a result, it has had adverse effects on social and economic development of the affected people, since they live on illegal land (land in all slums in Kenya belongs to the Government, hence inhabitants are squatters). Here 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 (Agatha, 2016). In some instances, the youth 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 prohibitive to the poor households in slums. Prolonging life through ARVs increases 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, hence the global silence! In some instances where there is lack of strong traditional support system, some families end up sliding further into destitution and extreme poverty.

2.2 Synopsis of HIV and AIDS status Globally

Although the global status is well documented in different reports, the recent estimates by the United Nations Agency for the control and prevention of HIV and AIDS (UNAIDS, 2016) indicate that the Sub-Saharan Africa (SSA) bears the highest burden of the disease according to (Kabiru, 2016). 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 (Kabiru, 2016). 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 (2014) 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 2016. 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. With similar sentiments, Fr¨olich (2015) observes that without an effective vaccine to stop HIV transmission and with very expensive medical treatment, information campaigns in vernacular media stations still play 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 in their own context. In Africa countries that were greatly under threat like Botswana and Swaziland have shown high prospects of containing the situation, with few AIDS related deaths reported (Volberrding P. A & Blattner W. A, 2017). Global country to country status are somewhat clearly reported.

2.3 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 these settlements worse as noted by Genish, (2015). Besides the poor sanitation, people purchase items in small quantities for each meal depending on their daily income levels. 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 youth from poor households 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 Sustainable Social Development Goal number one on eradicating extreme poverty and hunger. This is a common phenomenon in all the poor countries.

According to Ndinya (2010), there are serious concerns in slums in relations to social safety, unemployment and inadequate health facilities due to overpopulation arising from urbanization. As a result of the worsening economic hardships, slum residents result to desperate tricks of survival such as sexual hawking (half naked girls parading themselves on certain streets in towns), boda boda transport, 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 slums. 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 of their Aids infection since the kids are sexually pure (Ndolo, 2015). 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) as Dodoo (2016) puts it. This problem does not affect the young people alone. It exposes the whole population to hazards because they have inadequate funds to provide for adequate nutritious food content to their families and seek for better healthcare services at the same time. As Joseph (2012) asserts; 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 claim 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 anemia, 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 date few of these complications have been vigorously pursued. The disease is poverty (Jacobson, 2005:3) as quoted by Joseph et al (2012).*"

The findings of Marmot (2015) 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 Bank, (2012) emphasized 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. The current study intends to design an approach that could bridge this duo social gap.

2.4 The Survival Mechanisms of the Youth in Poor Slum households

Nyamongo (2015) observes that the youth from poor households 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, road site cooked food stuffs and to sale of cannabis. In Kenya the rich own the shanties (housing units in slums) and wholesale shops they 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 as Kiragu (2014) confirms. Those infected with HIV and AIDS survive on ARVs and food rations from the numerous health centres run by religious organizations and not for profit agencies in the area. Occasionally patients administer self-treatment using cheap locally acquired traditional herbs due to poverty (Nyamongo, 2015).

The poverty situation in slums is worse due to the arguably bad economic circumstances affecting the developed countries as a result of reduced donor aid on social development programmes as noted by Dodoo (2016). In addition, Africa lacks strong inter-governmental economic initiatives for regional development investment on health and poverty reduction. Similar sentiments are highlighted by the United Nations Development Programme (UNDP, 2016) who argue that poverty aggravates other factors that heighten the susceptibility of the youth to social risks as noted below:-

> *"Inability for the youth in slums to sexually control themselves lowers the age at which girls are introduced to sex. Studies show that younger adolescent girls sexually interact with much older men who are exposed to multiple sex partners, which makes them highly vulnerable to infections (Joseph, et al, 2010c").*

As UNDP 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 it influences 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 brown AIDS among the youth as indicated below:-

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

2.5 Theoretical Framework

According to Bertalanffy (1969) 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 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 centers that are diverse and equally dynamic systems in operations all of which influences the rate at which the poor who are affected by HIV and AIDS 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 Development Goals (SDGs) platform, goals no. 1 and 3 on no poverty and good health and well being respectively (Genish, 2015). 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.

3. Methodology

The study was conducted in selected slums in Kenya. It adopted a mixed research design with both qualitative and quantitate perspectives being predominantly applied. Multistage and purposive sampling techniques were used in identification and selection of the slums in accordance with HIV and AIDS prevalence, as well as identification of respondents. Out of the 136 females and 89 males, content analysis of the enormous existing data and reports, structured observation and in depth interviews, with key informants and focus group discussions were employed in data collection. Key informant, focus group discussion guides and a questionnaire were essential instruments to capture responses from respondents. The Statistical Package for Social Sciences (SPSS) was used to analyze quantitative data, while qualitative data was analyzed qualitatively through key themes emerging from respondents.

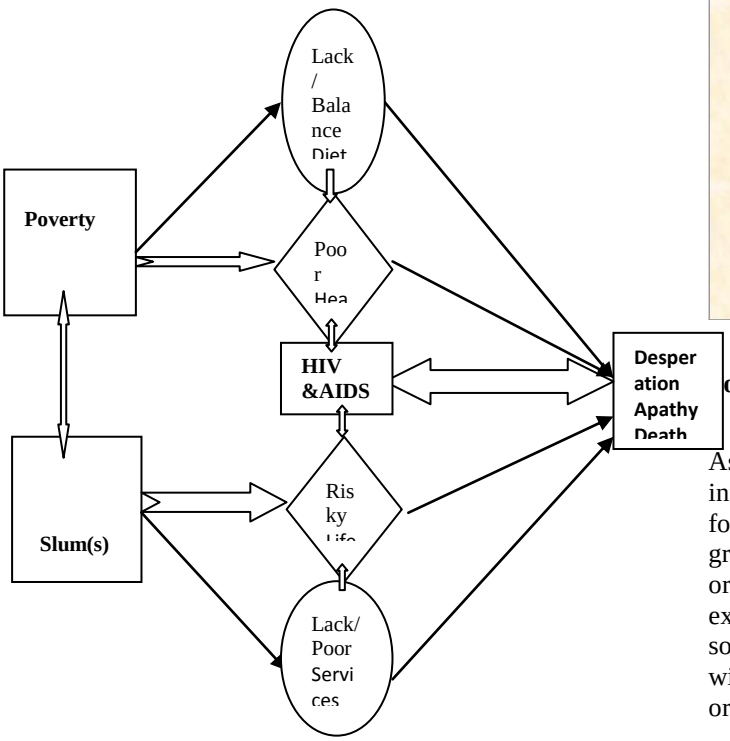
3.1 Research Questions

The study was guided by two questions: How does the youth from poor households in slums cope with the negative effects of HIV and AIDS in enhancing their livelihood security? and Which targeting procedures are used in HIV and AIDS intervention projects in slum areas to protect the youth?

3.2 Conceptual Framework: The Trio -Tragedy Model (TTM)

As illustrated on the model below, Lack of sustainable sources of income in slums make the youth 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 commercial sex, 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

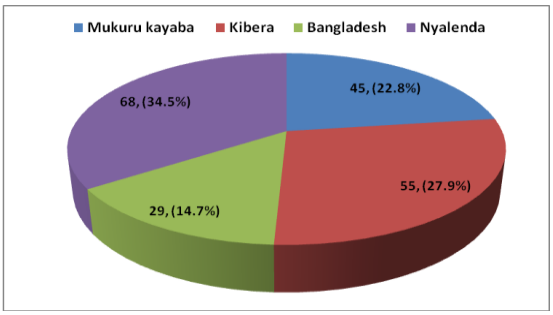
of survival are relatively cheaper. This study applies the **Trio-Tragedy Model (TTM)** to demonstrate how the HIV and AIDS pandemic and poverty not only weaken the household social livelihood security systems, but also pushes the household members beyond the poverty line mainly in slums leading to apathy, desperation and extreme suffering of the household members whose ultimate result is an eminent cycle of poverty.



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

3.3 Demographic Chracteristics of Respondents

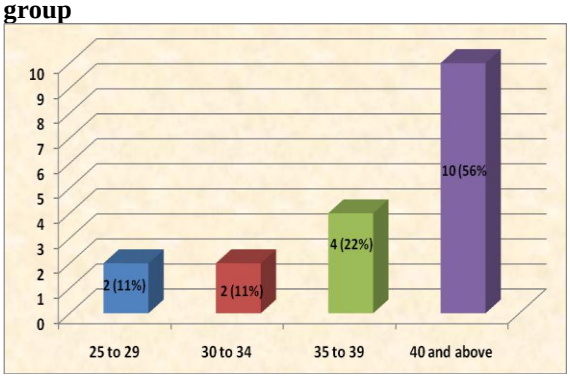
Figure 1: Distribution of the general Respondents based on the slum of residence



Source: Research Findings, 2018

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. Of these 141 were females against 74 males.

Figure 2: Distribution of Key Informants by Age-group



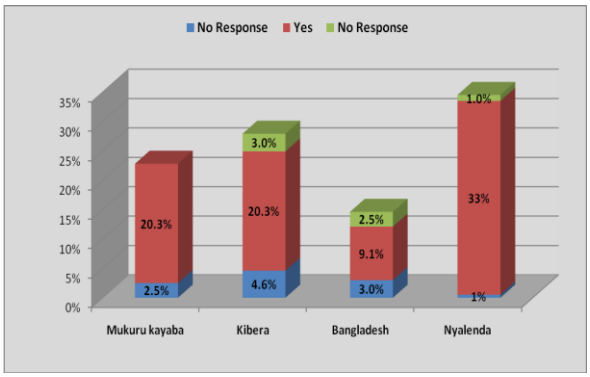
ource: Research Findings, 2018

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 and 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 and 29 and 30 to 35 with 2(11%) each respectively. This implies that some organizations preferred young leaders and coordinators.

An elderly focus group members in Nyalenda slums in Kisumu claimed as seen below:-

> *"....In the church, I have been a chairperson of our small neighborhood Christian 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 become orphans. They start to struggle to survive here in all manner of ways! We have seen children turn into lobbers, casual laborers and others turn into fish mongers in the lake victoria. Once the girls venture the sex industry, they die in a few years later just like their parents did". Most of them sell all what their parents had left and continue suffering".*

Figure 3: Respondent's Perception on Whether HIV and AIDS Led to Poverty among the Youth



Source: Research Findings, 2018

Figure 3 above illustrates that 82.7% of the respondents in the four slums observed that HIV and AIDS contributed to poverty among the youth, especially those who were orphaned by the scourge, as confirmed by members of one of the focus group *in Nyalenda slums in Kisumu:-*

> *……Yes, HIV eventually leads poverty among unemployed youth especially orphaned while in school or college. The worst are those children who were themselves infected. The youth become highly dependent on relatives and other institutions like the church for support"*

Similar sentiments were presented by one of the key informant in Nairobi as she observed:-

> *"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 very well, 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 families. However, we have buried many here. I have to confirm nevertheless, that the higher number of the infected is in slums, although these days, no one says what is happening, the silence is quite unfortunate! 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 poshy estates do not have People Living with HIV & AIDS (PLWHAs) but the worst affected are those in the slums more so the youth, who end up being quite poor"*

Table 1: 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	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

Source: Research Findings, 2018

As illustrated on table 1 above, three quarters of the respondents; 145(74.6%) in all the slum settlements HIV and AIDS was presented as a major cause of poverty A parent living with HIV and AIDS spend too much on medicine, (although ARVs are free) and food, living very little to support the youth comparative needs like a modern phones and pocket money. In essence young people from poor slum households may indulge in risky survival tricks like commercial sex to provide for the basic needs, when parents or they are themselves infected.

As one of the focus group member in Mukuru Kayaba slums in Nairobi indicated: -

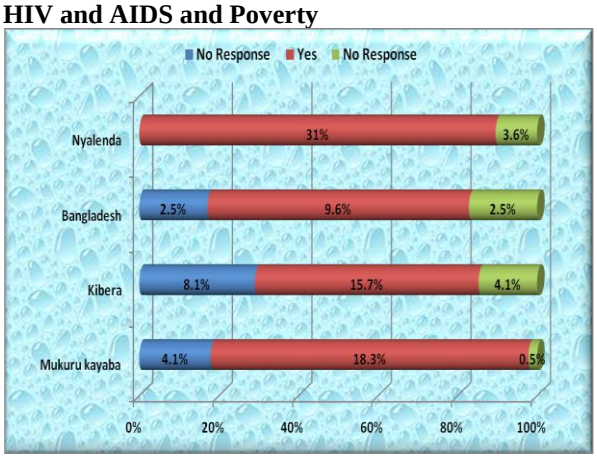
> *"HIV and AIDS contribute a lot to poverty increment in slums. For example, we are three wives in my household and are all infected, although we are getting free medicine from the Catholic Church health clinic. Our husband claims, we are the ones who infected him. Once all of us are dead, our children 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 led to poverty especially on the young orphans, they asserted that, this was the end result since they had no future without parental care and mutual support. Their education and training prospects are certainly compromised"

A new dimension emerged in Kisumu ndogo area of Kibera in Nairobi as an elderly respondent gave these sentiments on the link between poverty, HIV and AIDS:-

"…..this disease is not gone. People are just being ignorant! My 2 sons and a daughter have died. I have nine grand children now to feed and educate. Let others be silent, but I will talk about the dangers of this disease because our community here in south Nyanza is not safe at all….. This silence will only cause more desperation on us"

Figure 4: Respondent's Perception on Whether There Is a Relationship between HIV and AIDS and Poverty



Source: Research Findings, 2018

Across the four slums, 74.6% felt that the scourge is highly related with poverty. Likewise poverty causes the spread of infections, although the level of awareness are high in society. The only good news is that ARVs and treatment of other opportunistic diseases are now readily available which makes the situation appear normal and calm, as a youth focus group noted:-

"……Yes, HIV eventually leads to full brown AIDS which is quite expensive to manage; but these days no one will realize since people walk to health clinics and get free ARVs and nutritious supplements in some catholic centers. This way the situation looks normal. The challenge with the youth is that we have other serious needs beyond drugs and food"

4. Coping Mechanisms of the Poor

In regard to the coping mechanisms of the Youth living with HIV and AIDS (YLWHAs) 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, and getting known to be infected. With regard to infecting others and being re-infected, YLWHAs claimed to be using condoms, except with their best friends while others especially in Bangladesh argued that with ARVs there was no need to use any condom! What they needed was nutritious food to continue to live healthy and live a full life span.

In case of low immune levels, poor health and opportunistic infections, respondents indicated that YLWHAs in their respective slum areas claimed that the ARV treatment was a great relief. 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 had different coping mechanisms depending who they were and their social status. In regard to social support systems, they claimed that the disease created a flatform of 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 (Nairobi) was that family members organized fund raising initiatives called "harambees" (meaning pulling resources together for collective initiative). The funds were used for the sick person's upkeep and funeral expenses".

While those *in Nyalenda (Kisumu)* pointed out that affected family members normally provide for each other with weekly support from churches and sympathizers. One respondent claimed that:- "*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 in our midst".*

Another respondent observed:-

"*Availability of ARV treatment and counseling 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 of the disease, AIDS is not a threat anymore! she asserted.*

5. Survival tricks of Children affected by HIV and AIDS in Slums

The affected children survive through daily intake of ARVs and psychosocial therapy. The grandparents who

provide care to orphaned children are enrolled on the Government Cash Transfer Payments (GCTP) program 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 working in saloon shops in town or makeshifts. Child commercial sex is also an alternative source of living just like it happens in the beaches at the coast in Mombasa. 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 to survive. Similar question was asked to the key informants to elaborate on 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 never suspected by the police to be involved in such transactions. Most young women including some school going students engage on commercial sex after school.".*

5.1 The support Systems and Empowerment Opportunities

The support systems were evident not only 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 such as churches and NGOs 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 for the youth 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 quick income from local and foreign tourists at the beaches and hotels (in both Mombasa and Kisumu). Initially I was quite reluctant to really do this kind of thing. I did not know what to expect from a Man! But, I now put them (men) in to the box just easily! 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". I had no choice, but to look for money anyway". These Ladies have endless testimonies why they engage in sex work, even if they have other sources of income, they never shine away from this activity".*

6. Conclusions

. 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 like illicit brews and other activities.
- 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 centers for the youth (Mukuru promotion centers 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.
- The youth were found to be more vulnerable to HIV and AIDS, and consequently more likely to drop out of school or college and eventually get into drug abuse, prostitution and hence enhance the cycle of poverty and AIDS. Their coping mechanisms were found to be risky.

7. Recommendations

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

- Although availability of ARVs seem to have cooled down the anxiety, the silence needs to be broken. 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 to declare the youth as special cohort who require constant surveillance and attention since in the absence of a cure, they would continue to spread
- The youth should be categorized among the most vulnerable groups that needs special support programs through electronic communication since they are ever on WhatsApp of facebook platforms but not to cluster them together with the other poor in society where they are not clearly identified for social economic support.
- 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 program to provide them with vocational, business investment and entrepreneurial skills, management and accounting techniques.
- Religious and NGOs should avail special revolving investment fund (RIF) accessible to the special categories to supplement the youth and women funds; where those affected by HIV and AIDS could invest in any business of their choice and refund the funds with little interest margin to cater for the inflation rate. This would create permanent sources of income and make them self reliant and raise them above the poverty line and desperation. The fund would be genuine empowerment and support since it would be self sustaining.
- There is need for the central government to establish and strengthen youth capacity building for self employment such as training opportunities, Kazi Kwa Vijana (KKV) (youth empowerment jobs) to fully engage the youth and shun the current behavior 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, and drugs as a relaxer.

References

Agatha Christine, et al, (2016) *Expenditure patterns on food and non-food items in HIV/AIDS* nutrition supplements and development, Volume 10 No. 4. ISSN 16845374.

Bahemuka, Nganda and Nzioka, (2004) *Poverty Revised: An analysis and strategies towards poverty alleviation in Kenya;* Nairobi, Kenya, World Span.

Bertalanffy (1968) *The general systems theory: functions and application in society*.

Bettany, P. (2008): Systems theory: a critical review and diverse application in the contemporary World, Austria, Peterson Bros Ltd.

Bratislava Slovak, (2015). Youth Coping mechanisms on effects of HIV & AIDS in Kibera slums: *communities in Nairobi, Kenya*. Journal of Youth Studies, 13(4).

Dodoo F. Nii-Amoo, et al, (2016) *Urban-Rural Differences in the Socioeconomic Deprivation Sexual Behavior Link in Kenya.*

Fr¨olich Markus and Vazquez-Alvarez Rosalia (2014). *HIV/AIDS Knowledge and Behavior: Have Information Campaigns framework.* Nairobi: Government printer.

Ganesh. P. (2015): *Models for understanding social problems in slum, S*t. Elizabeth University, Series of hiv & Aids surveillance reports, Nairobi, Kenya.

UNAIDS, (2016) Global AIDS Updates a prospectus Report, UN, Geneva.

Government printer, (2012) *(KNASP III).* Nairobi: HIV & AIDS *affected and non affected households in Kisumu District, Kenya.* African health review.

Joseph Collins and Bill Rau (2012), *AIDS in the Context of Development*. UNRISD Program on Social Policy and Development in Africa, Bratislava, Slovak.

Kabiru Caroline (2016): *Transition into first sex among adolescents in slum and non-slum urban areas, exploration of HIV & AIDS transmission trends in Kenya (Unpublished PhD thesis.)*

Kimanga D. O et al (2014) Prevalence and Incidence of HIV infections, trends and risk Factors among the Youth in Nyanza region, INCRAF Reports.

Kirangu. J. P, (2016).: *Leadership challenges in strengthening national legal health monitoring instruments in slum settlements, Conference of world church leaders, March, 22nd -24th,*

Hilton Hotel, Nairobi.

Marmot Michael, (2015) *Health in an unequal world.* Lecture presented at the Royal College of health sciences, Boston, USA.

Muvengi, D. M.(2011). *Poverty, church, and development in Kenya: A case study of Kibera slums in Nairobi*. Thesis Submitted for Doctor of Philosophy (Missiology) at the Faculty ofTheology of the North West University NACC (2016) Kenya AIDS Response Report, Government Printer.

NASCOP (2016). Kenya HIV County Profiles, Government Printer National Aids Control Council (NACC).(2009): *Kenya National AIDS Strategic Plan 2009/10 –*

Ndinya, O. Steven (2014), *The African Traditional Health Therapies, Their Therapeutic Values and Effects on* world peace vol. XXII NO. 2, *59-75.*

Ndolo, U. M (2015)HIV and AIDS: the coping mechanisms of the Poor in Kenyan Slums; targeting procedures in safety-net programmes.

Tumushabe J. (2010), *The Politics of HIV & AIDS in Uganda*, Social policy and development paper Number 28. August 2010. United Nations Research Institute for Social Development.

UN Organization, (2015) Transforming Our World: the 2030 Agenda for Sustainable Development; Retrieved 2018. 03. 26.

Volberrding P. A & Blattner W. A, (2017) Journal of Acquired Immune Deficiency Syndromes (JAIDS), Vol. 76, Sept. 2017 (ISSN. 1525-4135)(online: ISSN: 1077-9450).

World Bank (2012) World Bank Health Annual Report, World Bank Press.