

UNIVERSITY OF
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International Development Department

Urban families under pressure in Kenya and the impact of HIV/AIDS

Urban household livelihoods and HIV/AIDS

Working Paper 2

Wendy Taylor and Harrison Maithya

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List of acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
APHRC	African Population and Health Research Center
ARV	Anti-retroviral Therapy
CACC	Constituency AIDS Control Committee
CBO	Community-Based Organisation
CBS	Central Bureau of Statistics
CSW	Commercial Sex Worker
DFID	Department for International Development
FBO	Faith-Based Organisation
FGD	Focus Group Discussion
GoK	Government of Kenya
HICAP	Highlands Community Assistance Programme
HIV	Human Immunodeficiency Virus
IGA	Income-Generating Activity
ITDG-EA	Intermediate Technology Development Group - Eastern Africa
KANCO	Kenya AIDS NGO Consortium
KDHS	Kenya Demographic and Health Survey
KNASP	Kenya National HIV/AIDS Strategic Plan
LASDAP	Local Authority Service Delivery Action Plan
MDG	Millennium Development Goal
NACC	National AIDS Control Council
NASCOP	National AIDS and STD Control Programme
NCC	Nairobi City Council
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
VCT	Voluntary Counselling and Testing

Exchange Rate: £1 = KSh 135

This was the rate at the time of the household survey, August/September 2005.

Preface and acknowledgements

The *Urban families under pressure in Kenya and the impact of HIV/AIDS* research project was coordinated by Professor Carole Rakodi of the International Development Department, School of Public Policy, University of Birmingham, assisted by Dr Emmanuel Nkurunziza. It was undertaken by Ms Wendy Taylor, an independent consultant, and Dr Harrison Maithya, Lecturer in the Department of Anthropology, Moi University, Eldoret, with the support of a number of organisations, both government and non-governmental, and many individuals, which the local research team wishes to gratefully acknowledge. Mention is made here of only a few of those concerned.

Several organisations gave particularly valuable assistance at the inception stage of the research, providing useful information within their respective spheres. These included several departments of Nairobi City Council, the Kenya AIDS NGO Consortium (KANCO) and the African Population and Health Research Center (APHRC). The support of the Central Bureau of Statistics (CBS) is also acknowledged, providing, amongst other things, data on the local area in which the selected informal settlement falls and an associated map.

The Provincial Administration, particularly the Chief, Mukuru Location, and the Assistant Chief, Mukuru Sub-Location, facilitated the research team's entry into the community. The members of the Mukuru kwa Njenga Sub-Location zonal committees also played an invaluable role in this respect, particularly at the time of the fieldwork.

Above all, sincere thanks are extended to the residents of the Mukuru kwa Njenga informal settlement, whose participation contributed so much to the research.

A small Local Reference Group was established, comprising representatives from the following government and non-governmental bodies:

- Kenya AIDS NGO Consortium (KANCO)
- Housing Development Department, Nairobi City Council
- District Technical Committee (Nairobi), National AIDS Control Council
- Nakuru Municipal Council/Constituency AIDS Control Committee, Nakuru
- Kayole Jua-Kali Association
- African Population and Health Research Center
- Adventist Development and Relief Agency.

An initial meeting at the inception stage of the research was held in June, 2005. A second meeting with the Local Reference Group and other interested participants was held on 22nd February 2007 to present and obtain feedback on a summary report of the findings and discuss their policy implications (Taylor and Maithya, 2007).

The UK government's Department for International Development supports policies, programmes and projects to promote international development. DFID provided funds for this study as part of that objective but the view and opinions expressed are those of the authors alone.

1 Introduction

1.1 Background¹

This report is concerned with one of two country studies conducted under the *Urban families under pressure: HIV/AIDS, economic decline, safety nets and livelihood strategies in Kenya and Zambia* research project. The aim of the research was to investigate the impact of short-term shocks and long duration stresses due to economic decline and ill-health, especially HIV/AIDS, on the livelihood strategies of poor urban households and their wider social networks, in order to inform policies intended to reduce poverty and achieve the Millennium Development Goals (MDGs). The project, which extended over the period October, 2004 - December, 2006, was undertaken in an informal settlement in the largest city: Nairobi.

1.2 Conceptual framework²

The sustainable livelihoods (SL) approach was adopted for the purpose of carrying out the research (Nkurunziza and Rakodi, 2005). According to this approach, households possess five forms of assets, namely human capital, financial capital, physical capital, social capital, and natural capital, as shown in Box 1.1. To secure their well-being and cope with the challenges of their economic, social, physical and political environments, households adopt livelihood strategies that draw upon these five forms of capital. Furthermore, it is contended that a household's ability to evade or reduce 'vulnerability' is dependent upon its initial asset endowment and its capacity to manage, access and transform its assets.

Box 1.1 Household livelihood assets

Human capital

The labour resources available to households, which have both quantitative and qualitative dimensions. The former refer to the number of household members and the time available to engage in income-earning activities. Qualitative aspects refer to the levels of education and skills and the health status of household members.

Financial capital

The financial resources available to people (including savings, credit, remittances and pensions), which provide them with different livelihood options.

Physical capital

Physical or produced capital is the basic infrastructure (shelter, water, energy, transport, communications) and the production equipment and means that enable people to pursue their livelihoods.

Social capital

The social resources (networks, membership of groups, relationships of trust and reciprocity, access to wider institutions of society) on which people draw in pursuit of livelihoods.

Natural capital

The natural resource stocks from which resource flows useful to livelihoods are derived, including land, water and other environmental resources, especially common pool resources.

Source: after Carney, 1998, p.7

¹ For fuller information on the context for the research project see Nkurunziza and Rakodi, 2005.

² See Nkurunziza and Rakodi (2005) for a fuller exposition of the sustainable livelihoods framework.

Based on this framework, the research **questions** that the project addressed are as follows:

- i. What evolving forms do the livelihood strategies of poor urban households take in a context of economic and social shocks and stresses? What explains the options open to, and the strategies adopted by, households? What are the impacts on those strategies of economic changes and ill-health, especially HIV/AIDS, and what are their outcomes in terms of poverty and well-being?
- ii. How are the relationships between household members changing, in particular household composition and inter-generational relationships, and why?
- iii. How are the relationships between urban households and their wider families and kinship networks in both urban and rural changing, as reflected in, for example, labour force entry, marriage patterns and practices, migration, remittances, caring for the sick and other dependents (including orphans), and inheritance?
- iv. How are the relationships between urban households and their social and political communities changing? What social safety-nets are available, and what access do households have to social networks and political institutions, with what outcomes?
- v. What attempts are being made to assist urban households build up their assets, increase their security, protect themselves against shocks and stresses, and deal with the effects of HIV/AIDS on their livelihoods? What are their outcomes?

1.3 Selection of research site

The selection process in Nairobi involved several steps. A number of potential settlements were known to the research team through previous research and for which both quantitative and qualitative data were available, thus offering a useful foundation for the current project. However, these were eventually ruled out for various reasons, including a concern expressed by organisations working within them about 'community fatigue' and 'over-exposure'.

Other leads were followed up, culminating in a field visit to several informal settlements in the Embakasi Division facilitated by the *Kayole Jua-Kali Association*, which is active in the area. An assessment of the settlements visited was made according to a number of criteria including population size and composition (mixed ethnic groups), a mixture of tenants and private owners, the presence of many poor quality/temporary dwelling structures as an indicator of poverty, access to baseline data, a basis for a sampling frame, and presence of an active organisation to facilitate community entry. This resulted in the selection of Mukuru kwa Njenga as the research site (Figure 1).

Figure 1 near here

Figure 1 The study area: Mukuru kwa Njenga, Nairobi

1.4 Methodology

1.4.1 Data collection

Both quantitative and qualitative methods of data collection were used. First, a household survey questionnaire was administered to a sample survey of households in the selected settlement. This was complemented by qualitative research conducted through focus group discussions and life histories. Secondary data collection at the national, city and informal settlement levels was also undertaken.

Household survey

Sampling

The drawing of the sample for the household survey proceeded on the following basis. Mukuru kwa Njenga settlement is divided into seven zones. The zones are similar but also distinct and different in terms of their physical size, the quality and size of the building

structures, the services available to the residents/tenants including water and electricity, the rents charged, and the state of the surrounding environment.

Sampling was done at two levels: plots/building and households. Since there is no official record of the number of plots in each zone, the plots were sampled on the basis of their accessibility and features that would make them easily identifiable. The latter included, for example, numbers previously marked on the walls and/or doors of some of the plots/buildings, and proximity to another, clearly identifiable building such as a clinic, shop or café. Each selected plot was then given a serial number, which became its unique identifier.

In the Mukuru kwa Njenga settlement, the plots accommodate one or two long buildings, which are sub-divided into several rooms, each of which is occupied by a household. A plot is, therefore, generally equivalent to a building. Between five and twenty plots/buildings were selected randomly from each zone, making a total sample of 76 plots/buildings. On average, there are between five and twelve households on each plot.

A systematic sampling procedure to sample the households was employed. On entering the plot/building, the first household was selected, the neighbouring one skipped, and the next one sampled. This was to avoid would-be interviewees in the adjacent dwelling overhearing the interview and discussion, as most of the walls of the structures are made of corrugated iron sheets. On average, three households per plot/building were interviewed.

Survey

The household survey questionnaire was broadly structured around the five livelihood assets. The household head or spouse was targeted for its administration, a household being defined as follows: "A household consists of a person or a group of people, related or unrelated to each other, who live together in the same dwelling and share a common source of food (they eat together)".³ In the absence of the head or spouse, any available adult member of the household was interviewed, though this was obviously not possible in relation to single person households. In single male households particularly, many men left their houses early in the morning for work, or to look for work, and returned home late, outside the interviewing hours.

With refusals and absent households, a total sample of 161 household interviews from the 210 households initially selected was completed, with a total of 629 household members.

Focus group discussions

During the administration of the questionnaire, potential participants for focus group discussions (FGDs) were identified on the survey form. Their selection for inclusion in FGDs was based on expressed willingness to participate, gender and ethnic origin, so as to capture a variety of views informed by cultural diversity. Four FGDs were held, each comprising between six and ten participants: two were mixed men and women, one men only and one women only. A total of 31 participants were involved in the discussions.

A number of themes were identified for discussion. These reflected those embedded within the questionnaire, but which were either not fully captured or not considered in depth in the survey.

Life histories

Three in-depth interviews were conducted to explore the life histories of adult members of households selected from the household survey sample. A set of selection criteria were developed for this purpose, viz. households which had experienced an adult death/s; and, households which displayed any of the following characteristics: an adult with a chronic/recurring illness; an adult suffering from illnesses symptomatic of AIDS; an adult self-

³ Source: Central Bureau of Statistics, 1994.

diagnosed or diagnosed by a health professional as HIV+; a wage earner who had lost a job.

Secondary data collection

Secondary data to provide information on the context of the research was also collected from a variety of sources, both formal and informal.

1.4.2 Data analysis

A quantitative and qualitative approach to analysis was adopted. With regard to the household survey, the SPSS package was used. Quantitative data is triangulated and compared with qualitative data. Data has been analysed around the five household livelihood assets. Qualitative data is largely presented as narratives.

The current report records the outcome of this analytical process.

1.5 Structure of the report

Following this introductory section, the report provides an overview of the country context in relation to the economic situation, socio-demographic and household characteristics; health and disease prevalence; urban poverty; and the national and local institutional, policy and legal framework. A similar form of presentation is applied at the city level in Section 3 to provide the Nairobi context and at the settlement level in Section 4, although on a much more detailed basis in respect of the latter, since a full analysis of the findings on the Mukuru kwa Njenga households is contained therein. Section 5 concludes by drawing together the threads from the preceding analysis, with a particular focus on the deployment of capital assets in relation to the livelihood strategies adopted by poor urban households. It then briefly looks at the policy implications of the latter and provides some pointers for policy makers on areas which need to be addressed if poor urban households' asset base is to be strengthened and their capacity to use their assets enhanced.

2 The country context

2.1 Economic situation⁴

The performance of Kenya's economy over the two decades prior to 2005 was extremely poor, profoundly and negatively affecting the overall welfare of the population. In the years just prior to the 2002 election, negative economic growth rates were experienced, with the number of people living in poverty rising and the standards of living deteriorating. The country's physical infrastructure and services - roads, railways, ports, telecommunications, electricity, and water - became dilapidated and, increasingly, act as a constraint on business and economic growth. The delivery of public services is inefficient and the rule of law has in many ways been compromised.

The greatest challenges facing the new government were "how to restore economic growth, generate adequate employment and reduce the high levels of poverty". In its *Economic Recovery Strategy for Wealth and Employment Creation 2003-2007*, the Government set out its broad goals to be met over this five-year period, including achieving high real GDP growth; containing the average annual inflation rate to below 5%; creating 500,000 jobs annually; and reducing the poverty level by at least five percentage points (RoK, 2003). Maintaining a stable macro-economic environment was considered to be a pre-requisite to the realisation of these goals.

Trends show that there was some economic recovery, with an increase in the GDP growth rate from 0.6% in 2000 to 2.8% in 2003 and 4.3% in 2004. There was also an increase in production in the agriculture sector (of tea and maize particularly), and a rise in the level of horticulture exports. Visitor arrivals rose considerably - from 1,037,000 in 2000 to 1,361,000 in 2004, with a corresponding increase in tourism earnings.

Trends in informal employment show a marked increase, from approximately 4.2 million jobs in 2000 to approximately 5.5 million in 2003 and 6.0 million in 2004. Nationally, most of the people working in the informal sector were absorbed in one or more of the following six main categories, in order of significance: wholesale, retail trade, hotels and restaurants; manufacturing industry; community, social and personal services; transport and communication; construction; and, others. It is anticipated that the bulk of the jobs created will continue to be in small enterprises within this sector; by the middle of the decade, there had been little employment generation in the formal, modern sector.

Government revenue increased from KSh 210.8 billion in 2001/02 to KSh 307.1 billion in 2004/05, with a simultaneous rise in public expenditure - from KSh 202.5 billion to KSh 352.6 billion over the same period.⁵

National inflation trends show that inflation increased after 2002 due to increases in food and fuel prices. Following a fall from a high overall inflation rate of 10% in 2000, down to 5.8% in 2001 and 2% in 2002, it rose steeply to 9.8% in 2003 and again in 2004 to 11.6%, though declining slightly to 10.3% in 2005.

2.2 Socio-demographic and household characteristics⁶

During the inter-census period 1989-1999, the population of Kenya increased from 21.4 million to nearly 30 million,⁷ the average population growth being 2.9% per annum. In 2004,

⁴ This sub-section draws upon three main sources: RoK (2003a) *Economic Recovery Strategy for Wealth and Employment Creation 2003-2007*, CBS (2005) *Kenya Facts and Figures 2005 Edition*, and RoK (2006) *Economic Survey, 2006*.

⁵ The £ exchange rate in 2004 was KSh 135

⁶ This sub-section draws particularly on the *Kenya 2003 Demographic and Health Survey Key Findings* (CBS et al, 2004).

⁷ 1999 Population and Housing Census (RoK, 2001).

the population was estimated at 33.6 million, with approximately 1 million more female members than male (51% compared with 49%). According to the 2003 Kenya Demographic and Health Survey (KDHS), just under half (45%) of the population was below the age of 15 years. Only 3% of Kenyans were 65 or older. This youthful age structure is typical of populations with high fertility and high mortality. In 2003, the total fertility rate was 4.9, suggesting that the fertility decline ongoing since 1975 might have stalled.

Most Kenyans have received some education. However, the 2003 KDHS shows that 13% of women aged 15-49 have had no education at all, compared with 6% of men (aged 15-54). Men also tend to complete higher levels of education than women. Almost 40% of men have at least some secondary education compared with only 29% of women.

Although the population remains predominantly rural, Kenya has been experiencing rapid urban growth, averaging 5.3% per annum in the last three decades. It is estimated that the urban population constitutes about a third of the country's total population; by 2025, it is predicted that this proportion will rise to more than half. There are some marked differences between urban and rural areas in respect of a number of demographic and household characteristics, as noted below. Strict comparisons between the two sets of statistics are not always useful and have their limitations, however.

While Kenyan households consist of an average of 4.4 persons, those in urban areas are smaller than those in rural areas (with an average of 3.5 and 4.7 persons respectively). Almost one in three households is headed by a woman. Female-headed households are less common in urban areas (26%) than in rural (34%). Women in urban areas tend to marry later (median age at first marriage 21.4 years) than their rural counterparts (median age 19.3). Women in urban areas also have smaller families - 3.3 children on average compared with 5.4 in rural areas.

Housing conditions also vary greatly according to area of residence. Thus, half of urban households have electricity, compared with only 5% of homes in rural areas. Urban households tend to have piped water into their compound or dwelling (49%) or get water from public taps (22%), whereas rural households rely primarily on "alternative" sources for their drinking water – springs, rivers, and streams (48%). However, for those in urban areas who do not have access to an urban piped water supply and who have to purchase water from vendors, the cost is high.

Urban households also have higher percentages of ownership of all consumer goods, such as radios, television sets, and mobile phones, with the exception of bicycles, which are owned by only 18% of urban households compared with 33% of rural households.

2.3 Urban poverty

The Government of Kenya (GoK) has adopted the universal measure of absolute or extreme poverty of a US dollar a day, with *absolute poverty* being defined as not having the basics to sustain human life: enough food to eat, clothes to wear and shelter. Accordingly, over half the population live in poverty: according to the government, 52% in 2003 (RoK, 2003b), while a survey by ActionAid in 2005 estimated that 57% of people were poor. Formerly, poverty was largely viewed and addressed as a phenomenon associated with rural areas. But with the dramatic rise in the number of people living in the country's urban areas, it is increasingly recognised to be as much an urban as a rural phenomenon. Indeed, according to the estimates of the 1997 Welfare Monitoring Survey, 49% of the urban population were defined as poor, the overall/absolute poverty line in the urban areas being calculated at KSh 2,648 per adult person per month at that time.

While strict comparisons between poverty in urban and rural areas have their limitations, evidence from the urbanisation process in developing countries suggests that the quality of life in some urban areas is even worse than in rural areas. Demographic and health surveys

carried out in Sub-Saharan Africa, including Kenya, indicate that the urban poor have less access to health services, and consequently exhibit higher mortality rates, than residents from other population sub-groups, including rural residents. Furthermore, a high percentage of the urban poor live in informal settlements, which by their very nature are replete with poor environmental factors that predispose their inhabitants to poor health.

2.4 Health and disease prevalence⁸

2.4.1 Health characteristics

The KDHS, which monitors the health situation in Kenya, indicated in 2003 that the infant mortality rate was 77 deaths per 1,000 live births and the under-five mortality rate was 115 deaths per 1,000 live births. This means that one in every nine children in Kenya dies before his or her fifth birthday. The comparable figures for 1998 were 73 and 110 deaths per 1,000 live births respectively. Infant and child mortality both appear to have increased between 1998 and 2003. It is not considered possible, however, to conclude conclusively that childhood mortality rates have risen in recent years.⁹

About 26,000 children under the age of five die each year from malaria. Use of mosquito nets, particularly insecticide-treated nets, is low for this group and for pregnant women, as it is in the population overall, falling far below the 2006 government target of 60% mosquito net use.

Knowledge of family planning methods in Kenya is almost universal: 94% of women and 97% of men know at least one modern method of family planning. Contraceptive use, however, increased only slightly between 1998 and 2003 amongst married women - from 34% to 41%. Moreover, rates of discontinuation of contraception increased between 1998 and 2003, from 33% to 38% of users.

Almost 90% of Kenyan women receive antenatal care from a medical professional. In 2003, the majority (71%) of women who obtained antenatal care went to government sources, of which the most common are health centres and government hospitals. Of all pregnant women, 42% reported that they had been assisted during childbirth by a doctor, nurse, or midwife. Another 28% have a traditional birth attendant and 8% deliver alone. Almost 60% of births occur at home. The vast majority (81%) of women who delivered at home did not have a postnatal check.

Adult mortality, which is estimated through the reported survival status of a woman's siblings, showed a substantial rise between 1998 and 2003. At younger ages (15-34), women's mortality is higher than men's, which is considered unusual, since male mortality typically exceeds female mortality. It is highly probable that this is due to the HIV/AIDS pandemic. Maternal mortality represents 15% of all deaths of women of childbearing age (15-49).

2.4.2 Disease prevalence

The 2003 KDHS indicated that 6.7% of Kenyan adults were infected with HIV, with a higher percentage of women (8.7%) infected than men (4.6%). Men and women residing in urban areas have a significantly higher risk of HIV infection (10%) than rural residents (6%). The survey also revealed that almost all Kenyan adults had heard of AIDS, and three-quarters know someone personally who has AIDS or has died of AIDS. Nearly half of all Kenyan women (48%) and three-fifths of men (62%) had heard of voluntary counselling and testing

⁸ The main source of information for this sub-section is the *Kenya 2003 Demographic and Health Survey Key Findings* (CBS et al, 2004).

⁹ Childhood mortality is measured by the following: *infant mortality rate* (the probability of dying before first birthday) expressed per 1,000 live births; *child mortality rate* (the probability of dying between first and fifth birthdays) expressed per 1,000 children surviving to 12 months of age; and *under-five mortality rate* (probability of dying before fifth birthday) expressed per 1,000 live births.

(VCT). Prior to the 2003 KDHS, only about 15% of women and 16% of men had been tested for HIV. Amongst men and women eligible for HIV testing under the survey, response rates were considerably higher in rural areas than urban (79% versus 62% overall).

Overall, however, knowledge of HIV prevention measures is quite low; for instance, only 58% of women and 70% of men reported that they knew that the risk of getting HIV can be reduced by using condoms and limiting sex to one faithful partner. Prevention knowledge is higher in urban areas and among those with higher levels of education.

Although a recent survey, the *Household Health Expenditure and Utilisation Survey*, which was conducted in 2003, reported that HIV/AIDS kills approximately 700 Kenyans every day, malaria remains the most prevalent disease, followed by respiratory infections, diarrhoea, tuberculosis, accidents and injuries, in that order. As cited in the *Economic Survey 2006* (RoK, 2006), malaria is the leading cause of both morbidity and mortality. It affects some 20 million Kenyans annually and accounted for 33% of all out-patient cases in 2005. Mortality from the disease is estimated at 30%. Approximately 170 million working days are lost each year through malaria, impacting negatively on the national economy and on people's livelihoods. Children and pregnant women are at a higher risk of contracting malaria. The disease frequently leads people to seek medical care.

Disease of the respiratory system is the second main cause of morbidity, accounting for 25% in 2005, up from 23% in 2004. Thus together, respiratory infections and malaria accounted for well over half (58%) of all morbidity cases reported in 2005.

2.4.3 Health expenditure

The *Household Health Expenditure and Utilisation Survey* of 2003 also indicated that nearly half of the population does not seek medical care because they cannot afford it. Others funded their medical costs through *harambee* contributions, borrowing, or selling some of their household assets.¹⁰

Total health expenditure on AIDS in 2001/2002 was KSh 8.2 billion, half of it from donors. While the Ministry of Health is the major provider of AIDS services, households make a substantial contribution through direct out-of-pocket payments.

2.5 Institutional, policy and legal framework

Efforts to reduce poverty and to progress towards the achievement of the MDGs takes place within a specific institutional, policy and legal framework, as briefly described below.

There is a two-tier system of government in Kenya - national and local government. National government comprises over thirty ministries. Amongst those of relevance in the current context are: the Ministry of Finance; the Office of the President - Provincial Administration and Internal Security; the Office of the Vice-President and Ministry of Home Affairs (Children's Services); the Ministry of Planning and National Development; the Ministry of Health; the Ministry of Gender, Sports, Culture and Social Services; the Ministry of Lands and Housing; and the Ministry of Local Government. The modus operandi of the national government continues to be a very centralised one.

In urban areas, local government comprises either municipal or town councils, with one city council, Nairobi. A council comprises both a political arm - elected and nominated councillors and a mayor, and an executive/administrative arm, made up of civil servants. For many years, local government in Kenya has been severely hampered in its operations by the strong central control placed upon it by the Local Government Act (Cap 265), which gives the

¹⁰ *Harambee*, which means 'all pull together', refers to a long-standing tradition in Kenya whereby local communities raise funds for local public goods.

Minister of Local Government considerable powers over local authorities. Local government also has to operate in parallel with other systems that undertake different aspects of central government activity from national down to local level, which has led to further diminution of the role of local authorities, competition for scarce resources, duplication of effort in some cases and absence of activity at the local level in others.

Notwithstanding, through various means, such as the Local Authorities Transfer Fund, a discretionary block grant from central government; participatory approaches, and partnership arrangements, local authorities are initiating and supporting development activities at the local level. In respect of addressing the problem of HIV/AIDS in their areas, local authorities have been encouraged through the Ministry of Local Government to earmark a budgetary allocation for HIV/AIDS activities. The Association of Local Governments in Kenya, a local government membership and lobby group, has supported an initiative under the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa to form and strengthen municipal HIV/AIDS teams. Some of the activities under the initiative include training municipal leaders on HIV/AIDS and encouraging councillors to form HIV/AIDS committees in their wards.

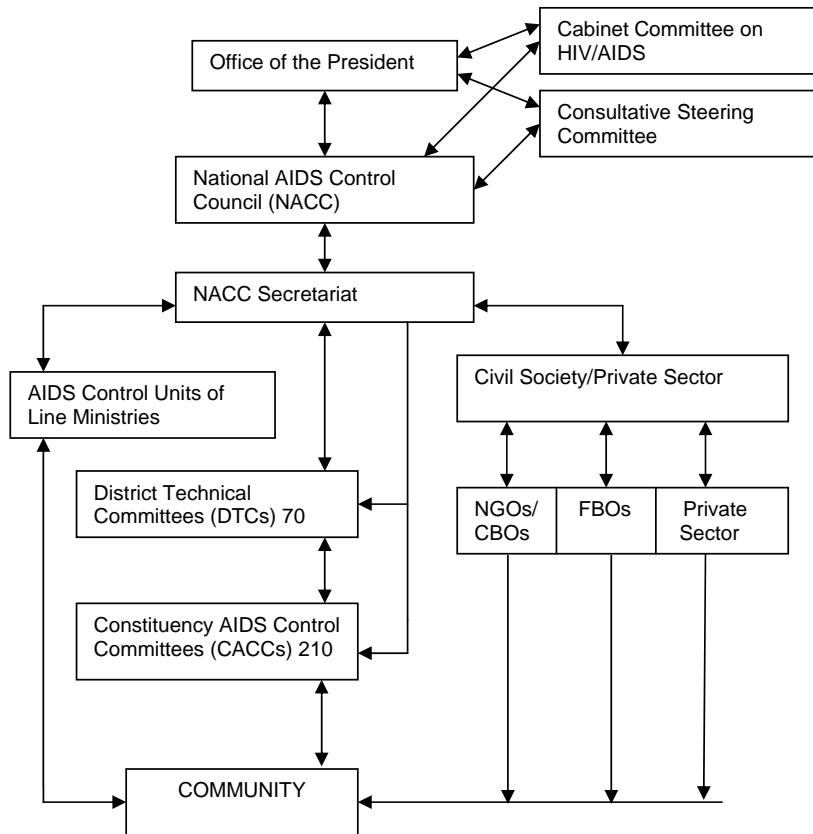
The Provincial and District Administrations, which are headed by a Provincial Commissioner and District Commissioner respectively, are the most entrenched of the systems paralleling local government. They are charged with coordinating central government affairs through an administrative system which reaches down to communities through district officers at divisional level and chiefs and assistant chiefs at location and sub-location levels. Together these personnel wield considerable power over the social, economic and political life of urban communities.

As illustrated in Figure 2, the National AIDS Control Council (NACC), another institution of relevance in the context of the current research, also has a hierarchical structure, operating at the local level through Constituency AIDS Control Committees (CACC). NACC, which was established in 1999 and is the overall policy-making body on matters relating to HIV/AIDS in Kenya, is mandated to perform the following functions:

- to mobilise resources for AIDS control and prevention;
- to coordinate and supervise implementation of AIDS programmes in the country;
- to mobilise all stakeholders to participate in AIDS control and prevention;
- to provide a framework to guide implementation activities at all levels;
- to oversee utilisation of resources allocated to HIV/AIDS activities; and
- to coordinate monitoring and evaluation of national responses.

It coordinates the implementation of HIV/AIDS programmes and activities through District Technical Committees (DTCs) and Constituency AIDS Control Committees (CACCs), which, in turn, provide coordination, supervision and monitoring mechanisms at the district and local (constituency and community) levels.

Figure 2.1 NACC Institutional Framework



Source: NACC (2005), p.65

The national policy framework is rich and diverse. The key policy/planning documents which guide development and economic growth and approaches towards poverty reduction were, at the time of the study: the Economic Recovery Strategy for Wealth and Employment Creation (ERSWEC) (2003-2007), the Poverty Reduction Strategy Paper (PRSP) (2001-2003) and the National Poverty Eradication Plan (2000-2015), and the National Development Plan (2002-2008). Other policy documents of relevance include the National Housing Policy (Sessional Paper No.3 of 2004), and the Kenya National HIV/AIDS Strategic Plan (KNASP) 2005/6-2009/10 (NACC, 2005).

The KNASP sets out to provide one common action framework as the basis for all partners, both national and international - government, civil society, the private sector and development partners - to work together to ensure an effective, enhanced national response to HIV/AIDS. In addition to providing an overall vision, goal and targets for the national response over the five-year period, the plan identifies priority areas and key strategies for intervention by its partners; establishes a results framework, which guides interventions across all sectors by identifying specific tangible results to be delivered in each priority area for implementing agencies; sets up a review process through which partners can jointly review, consult on, and coordinate key interventions; and, empowers civil society and private sector stakeholders to engage effectively in the national response. Furthermore, it serves to operationalise the Government's commitment to fight HIV/AIDS set out in the ERSWEC.

However, implementation of the policies, sessional papers and strategies which comprise the policy framework is generally weak. It is also largely oriented towards the rural sector. Indeed, there is little ongoing rigorous policy debate about the urban sector and associated issues of:

- the increasing incidence of urban poverty;
- rapid urbanisation;
- the additional demand for services, which both these phenomena will undoubtedly bring about, in a situation where local authorities' capacities and resources are severely stretched;
- the role of the city and towns in relation to national and local economic development and thus to poverty reduction; and,
- urban-rural linkages and how these could impact on strategies designed to reduce poverty.

The corollary of this is that there is a dearth of policy directives focusing on the urban sector. Furthermore, with their limited autonomy and capacity, the role of local authorities in addressing those urban issues which directly impinge upon them, through local policy-making or comprehensive local development planning, is highly constrained.

3 The Nairobi context

3.1 The local economy

As the capital of Kenya and the seat of national government, and as a regional and international hub, Nairobi plays a dominant role in the country's economy and generates over 45% of the national gross domestic product. It is a centre for international diplomacy, finance, banking and commerce and provides employment for its residents and commuters from its hinterland: 25% of Kenyans and 43% of the country's urban workers are employed in the city. Its industrial zones offer employment for many of the inhabitants of the informal settlements, often as casual workers.

According to the 1999 Census, the 'primary activity' of individuals (of age five years or more) was as follows: 39% waged employees, 14% own business/agricultural holding/own account workers, 21% unemployed, including both those seeking work and those not working; and 33% student/retired/ incapacitated/ home-maker. Many of those falling in the second category are working in the informal or *jua kali* sector. In 2005, of the 6.4 million persons working in this sector nationally, Nairobi Province accounted for 1.5 million (24%), up from 1.1 million in 2001. Community, social and personal services absorbs the highest number of people in informal sector employment, followed by manufacturing industry; wholesale and retail trade, hotels and restaurants; transport and communication; and construction.

Despite its significance in the local economy and to the capital's labour force, a clear policy for the development of the informal sector in Nairobi is not evident. As cited in a recent urban sector profile of Nairobi (UN-HABITAT, 2006), the informal sector is neither adequately regulated nor supported by the City Council, although every year it employs a growing share of the capital's labour force. For example, "Kiosks and hawkers are still largely seen as threats to city development instead of opportunities and resources" (UN-HABITAT, 2006). In addition, poor and deteriorating physical infrastructure and services - roads, transport, electricity, water and telecommunications - as well as insecurity, have for many years constrained both the informal and the private, formal sectors and, thereby, the economic development of the city.

Indeed, despite Nairobi's pivotal role in the economy, it would appear that there is little strategic thinking going on about its future potential based, for instance, on a discussion of cities/urban centres as being the engines of economic growth. The current metropolitan development plan/strategy dates from 1973, but progress with the preparation of a new strategy, which would address issues of poor infrastructure and services and help stimulate investment, is painfully slow.

For comparative purposes, it is also worth noting here the inflation rate trends recorded for Nairobi disaggregated by two main income groups: Nairobi lower income group, which constitutes about 80% of the city's population and into which the majority of population of the study informal settlement would fall; and, Nairobi middle and upper income group.

Table 3.1 National and local inflation trends

Income group/ inflation rate	2001/ 2000	2002/ 2001	2003/ 2002	2004/ 2003	2005/ 2004
Nairobi overall	3.7	1.8	9.6	13.2	11.4
Nairobi lower income	3.6	1.7	10.8	14.4	11.7
Nairobi middle and upper income	4.3	2.1	4.8	8.0	10.1
Kenya overall	5.8	2.0	9.8	11.6	10.3

Source: RoK (2006) Economic Survey, 2006

Table 3.1 shows that, although the recent fall in the inflation rate from its peak in 2003/4 was more pronounced for the basket of goods and services consumed by the lower income group, the rate of inflation for this group is still higher than both the average Nairobi and the national rates of inflation.

3.2 Socio-demographic and household characteristics

According to the 1999 Census, Nairobi's population stood at 2.3 million, representing about 7% of Kenya's total population. The population pyramid for Nairobi is markedly different from the structure for the national population (APHRC, 2002). There are slightly more men (51%) than women (49%). The proportion of young people aged 0-14 years is considerably smaller in the Nairobi population than nationally: 31% compared with 47%. By contrast, close to 40% of the Nairobi population are men aged 15-49 compared with approximately 25% nationally. The proportion of females in this age group does not differ significantly between the city and national populations (29% and 26% respectively).

The city has the smallest percentage (20%) of female-headed households in the country (33%). Approximately 32% of Nairobi's adult population is categorised as "economically inactive".

The population of the city has grown more than ten-fold since 1960. The average annual growth rate during the 1950-1965 period was 9.2%, amongst the fastest growth rates of any urban agglomeration in the world at that time. Recent annual growth rates remain high, hovering at just below 5% in most years (Taylor and Gitau, 2003). It is predicted that the annual growth rate will decrease over the next 15 years (UNCHS and RoK, 2001), although the city's share of the national population will rise to approximately 10%.

It is estimated that nearly 60% of the city's residents live in informal housing, that is, informal settlements, which cover about 5% of the total area used for residential purposes.¹¹

A recent World Bank study of Nairobi's informal settlements (World Bank, 2006), in which a household sample survey of 1,755 households from 88 informal settlement enumeration areas was administered, provides some interesting contextual demographic data.¹² As shown in Table 3.2, there are more males than females, the ratio being 55:45, with a greater proportion of both school-age children (5-14) and adults (defined as 15 years or more) being male (51% and 58% respectively). There are more adults than children, the ratio being 66:34. When compared with the country as a whole, both urban and rural areas, informal settlements have disproportionately few children. The average household size is relatively small at approximately 3, in part because of the high proportion of single person households (nearly a third). Over four fifths of heads of household are men.

It is also noted from the same study that, although two thirds (68%) of adult slum dwellers are economically active, the unemployment rate is high (26%). Disaggregation by gender shows that 49% of females consider themselves to be unemployed compared with 10% of males.

¹¹ The percentages are updated from estimates made by Matrix Development Consultants/USAID, 1993.

¹² For census purposes, CBS has divided Nairobi into about 4,700 enumeration areas (EAs), of which 1,263 are categorised as 'informal settlements'. The 88 EAs in the World Bank sample were selected randomly from this subset.

Table 3.2 Socio-demographic characteristics, Nairobi informal settlements

	N	%
Household Size and Composition		
Sample Households (n)	1,755	
Household size (n)	2.97	
Single-person households (n, %)	560	31.9
Female-headed households (n, %)	310	17.7
Mean age of household head (yrs)	34.8	
Median age of household head (yrs)	32.0	
	%	%
Gender Profile		
	Male	Female
Age 0-4	49.0	51.0
Age 5-14 (school age children)	51.0	49.0
Age 15+ (adults)	58.0	42.0
All individuals	55.0	45.0

Source: World Bank, 2006, p.23

3.3 Poverty and informal settlements

Population increases have generally been accompanied by a rapid rise in the level of poverty. Although poverty in Nairobi decreased very slightly between 1992 and 1994, reflecting the national situation, it increased dramatically between 1994 and 1997. The proportion of Nairobi's population in absolute poverty rose from 26% to 50% during that period. The latter percentage was marginally higher than that (49%) for the nation's urban population as a whole. It is likely that the proportion living in poverty has increased quite considerably since then.

As described in the recent study of Nairobi's slums (World Bank, 2006), a poverty mapping exercise carried out by the Central Bureau of Statistics (CBS) in 2003 estimated the poverty rate at 44% for Nairobi, with a poverty headcount varying from below 20% in the richest areas to over 70% in the poorest areas of the city. The study further explains that, "These numbers are calculated by using proxy indicators (such as access to water and quality of housing) rather than actual income or expenditure data" (World Bank, 2006). This means that, because they have poor quality housing and infrastructure, the residents of informal settlements "are almost by definition classified as poor".

It is also worth noting the expenditure-based 2004 poverty line used for the purpose of the study, which was based on the GoK 1999 poverty line adjusted for inflation. It was defined as an expenditure of KSh 3,174 (US\$ 42) per adult equivalent per month excluding rent.

While there is no official definition of informal settlements, they can be described as unplanned, informal housing areas, characterised by poor housing conditions, a lack of even the most basic urban services, and high densities - typically, 250 dwelling units per hectare (compared to 25 per hectare in middle income areas and 15 per hectare in high income areas). Moreover, their residents have insecure and ambiguous tenure status, which limits them from enjoying their rights as urban citizens, and experience higher morbidity and mortality rates higher than those in other parts of the city, particularly among children, caused by disease stemming from environmental conditions.¹³ The incidence of drug abuse is also significantly higher (Matrix Development Consultants, 1993).

No exact specification of informal settlements in Nairobi in terms of their number, name, physical size or population level is available. However, according to Ngau (1995), there were some 134 "informal settlement villages" located across the city at that time. The settlements are commonly disaggregated into villages, areas or zones, although the basis of such

¹³ Further information on informal settlement residents and ill-health is provided in sub-section 3.4 below.

disaggregation is usually not evident. It is also known that the settlements vary considerably in terms of population and area - for example, Spring Valley settlement occupies 1.7 hectares while Kibera occupies 225.6 hectares (UNCHS and GoK, 2001).¹⁴

They vary, too, in terms of land tenure arrangements, housing tenure forms, percentage of structure owners versus tenants, and ethnic origins and cultural traditions of their inhabitants. Recent observations indicate a mushrooming of such settlements within the city.

3.4 Health and disease prevalence

The 2003 KDHS indicated that the infant mortality rate in Nairobi Province was slightly lower than the national figure, standing at 67 deaths per 1,000 live births, down from 73 in 2000 (CBS et al, 2004). The child mortality rate was 30 deaths per 1000 live births. This was significantly higher than in Central Province, which had the lowest child mortality rate of all the provinces: 10 deaths per 1000 live births. The under-five mortality rate was 95 per 1000 live births, down from 110 in 2000.

The survey reported that 39% of children in Nairobi had experienced an episode of high fever during the reporting period, a probable manifestation of malaria even though the city is considered a malaria-free zone. 16.4 % of children under age five had symptoms of acute respiratory infection (ARI), which is comparable with other regions in the country. Poor hygiene, which includes poor faecal matter disposal, contributes to the spread of disease, especially diarrhoea. About 14% of Nairobi children under age five reported an episode of diarrhoea, but only 35% were taken to a health provider compared with 46% nationally. 41% of children with diarrhoea in Nairobi had been given oral rehydration therapy (ORS), 64% increased fluids and 11% a home remedy. However over a fifth of children (22%) had not been provided with any treatment.

Recent research undertaken in Nairobi has identified strong links between urban poverty and ill-health, particularly amongst children, with the environment being a key intervening factor (Amuyunzu-Nyamongo and Taffa, 2004). Conducted in four informal settlements, the research showed that members of the communities concerned identified respiratory tract infections, diarrhoea, malaria, skin problems and malnutrition as the five leading illnesses among children under five. Their mothers linked these illnesses to lack of adequate and clean water, lack of sanitation facilities, poor garbage disposal and drainage, lack of adequate and nutritious food, and pollution.

Another recent study conducted in Kibera, the largest informal settlement in Kenya, showed that the prevalence of malnutrition was higher than the national average (Kariuki et al, 2002). Extensive malnutrition can be defined as a public health problem. Other findings indicated that children born to teenage mothers are more likely to get malnourished; and children in large households are at risk of under-nutrition, probably due to inadequate food intake. It also revealed a high morbidity rate amongst young children, with a significant relationship between chronic malnutrition and morbidity. An association was also found between illness and malnutrition.

Having children who are frequently ill impacts on the wider household in various ways. Parents spend money and time on treatment and care, money that they often do not have. For mothers who work, it may involve the suspension of their income earning activity to care for the sick child, which is costly given the temporary nature of much casual work and the prevalence of single-person businesses. Diverting family resources to provide care to a sick child may have implications for the provision of other basic necessities such as food.

¹⁴ Accurate estimates of population levels in each of the informal settlements are notoriously difficult to obtain, given the inadequacy of the official census counts and the different methodologies applied in the many surveys that are undertaken.

According to the 2003 KDHS, 96% of women in Nairobi receive antenatal care from a medical professional - 29% provided by a doctor, 67% from a nurse/midwife (CBS et al, 2004). Thus, only a small, though important, proportion (4%) of women do not receive such care. 38% of deliveries take place in a public health facility, with nearly 40% taking place in a private sector facility. Nairobi has a significant proportion (22%) of women delivering at home, although much lower than Kenya as a whole (60%) and the lowest amongst the provinces. About 34% of deliveries are assisted by a doctor, another 45% by a nurse/midwife, 9% by a traditional birth attendant (interestingly, significantly higher than Central region at 5%), and about 8% by a relative/friend.

The 2003 KDHS indicated that Nairobi has the second highest rate of HIV infection in the country - nearly 10% - after Nyanza Province at just over 15%, with nearly 12% of women infected and just under 8% of men.

As in the entire country, knowledge of HIV and AIDS is universal in Nairobi and a large percentage of people surveyed in 2003 - 82% of men and 71% of women - knew someone personally who had AIDS or had died of AIDS. Although knowledge of voluntary counselling and testing was also high, a large number of people (73% of men and 71% of women) had never been tested for HIV and AIDS at a VCT facility. The survey also reported that men are more likely to be tested for HIV than women (55% and 50% respectively), although there are more refusals of testing by men (22%) than women (15%).

Knowledge of HIV prevention methods is widespread, with 75% of women and a slightly higher number (82%) of men in 2003 knowing that condoms can reduce the risk of contracting HIV during sexual intercourse. Overall, 44% express accepting attitudes toward HIV- and AIDS- infected persons in respect of, for instance, willingness to care for a HIV-positive relative at home, and buying fresh vegetables from a vendor with AIDS. There were discernible gender differences in this respect, with a lower proportion of women (36%) than men (53%) expressing accepting attitudes.

Such findings on awareness of HIV prevention were reflected at the informal settlement level, with residents being well informed about preventing the further spread of the virus. However, a Nairobi cross-sectional slums survey undertaken in 2002 showed that a large number of uneducated women were not well informed about ways of avoiding HIV infection and believed themselves to be at minimal or no risk of contracting the infection (APHRC, 2002).

The latter survey also found that adolescent boys and girls in the slums experience far worse reproductive health outcomes than their colleagues elsewhere in Kenya. They initiate sexual and reproductive activities much earlier and are at increased risk of unwanted pregnancies and sexually transmitted infections, including HIV.

3.5 Stakeholder identification

The following provides a brief overview of some of the key stakeholder institutions in Nairobi of particular relevance to the current study. These have a critical role to play in relation to one or more of the following areas: the provision of services, the development process, poverty reduction, and prevention of HIV/AIDS.

3.5.1 Nairobi City Council¹⁵

The legislative arm of Nairobi City Council (NCC) comprises some 55 elected councillors, who represent their local constituencies or wards, and 18 nominated councillors. It has a Mayor and a Deputy Mayor, who are elected from amongst the councillors. The full Council operates through a system of committees served by a departmental structure that forms its

¹⁵ This sub-section quotes extensively from Taylor and Gitau, 2003.

executive arm, staffed by civil servants. There are sixteen Committees and ten Departments. The departments are structured on traditional, hierarchical and sectoral lines.

It is through the departments that NCC carries out its mandated responsibilities. Under the Local Government Act (Cap 265), the City Council is charged with the provision or “causing the provision” of services including health (preventative and primary health care), education (primary), water and sewerage,¹⁶ shelter and basic infrastructure, and their management and maintenance, and the management of development within Nairobi.

However, it is widely acknowledged that, for at least the last decade or two, NCC has not been operating as an efficient entity and has been unable to fulfil its mandate. Its *modus operandi* has been characterised by the following:

- the politicisation of the Council's operations;
- poor relationships between councillors and officers;
- lack of autonomy to run its own affairs;
- financial mismanagement and corruption;
- under-capacity at higher management levels, with a shortage of professional/ technical personnel and a surplus of unskilled workers;
- deficiencies in the overall structure of NCC and in its management;
- a ‘crisis-management’ approach to the city’s problems with “no vision”;
- an outdated metropolitan growth strategy and an iniquitous land delivery system; and
- inconsistent perceptions of poverty and responses to informal settlements.

One outcome of this is that, on a per capita basis, Nairobi’s services have been declining along with the Council's revenue base. While this adversely affects all the city’s citizens, it tends to impact most severely on those who are already disadvantaged and vulnerable. Most essential services, in any case, barely extend to the informal settlements, where the majority of the city’s disadvantaged and vulnerable citizens live. These constitute ‘unplanned areas’, in which the Council has no statutory obligation to provide services.

3.5.2 Provincial Administration¹⁷

The boundaries of the city are contiguous with those of Nairobi Province (and also Nairobi District), which is administered through the Provincial Administration headed by the Provincial Commissioner (PC), essentially operating in parallel to the NCC. In Nairobi, the PC’s Office is extremely powerful, being responsible, amongst other things, for security and land matters. It is also coordinates the provincial representatives of functional ministries, which have the mandate to provide services such as health and secondary education. The PC is at the apex of a hierarchy reaching down to informal settlement communities through district officers at divisional level, and chiefs and assistant chiefs at location and sub-location levels, all of whom act as the mouthpiece of the government.

Through the powers vested in the PC, the Provincial Administration can considerably influence the livelihoods of the poor in Nairobi. This applies particularly in relation to land - the PC has powers over land use and land allocation and can order evictions. While these powers are not unlimited, as there are some checks and balances, the PC’s decisions in the main go unchallenged. On the other hand, the PC has very few other resources. Budgets for development/improvement and services lie with functional ministries and NCC. There are few checks and balances, however, at the lower levels of the provincial administrative hierarchy.

3.5.3 Nairobi District Technical Committee

¹⁶ This service has now become the responsibility of the Nairobi Water and Sewerage Company under the new Water Act of 2002.

¹⁷ This sub-section quotes substantially from Taylor and Gitau, 2003.

Under the NACC organisational and functional arrangements illustrated in Figure 2 above, the Nairobi District Technical Committee (DTC) is the body responsible for coordinating and backstopping HIV/AIDS activities being implemented by each Constituency AIDS Control Committee (CACC), such as the Embakasi CACC which covers the Mukuru kwa Njenga area. CACC core functions include:

- putting in place strategies and activities that address specific needs of orphans, widows and widowers, and people living with HIV/AIDS (PLWHA);
- identifying the factors that contribute to HIV/AIDS spread in the community and facilitating AIDS education in the community;
- promoting positive health-seeking behaviour, including addressing cultural practices, with an emphasis on safer sex, nutrition, sexually transmitted disease (STDs) management, voluntary testing and counselling, and improving reproductive health and health overall;
- encouraging promotion of income generating activities to accelerate poverty reduction among vulnerable groups and the less fortunate; and,
- facilitating the collection and compilation of data on orphans and vulnerable children (OVC), and widows and widowers.

3.5.4 Non-state actors

A wide range of non-state actors are active in addressing, in one way or another some of the challenges facing the city - the scale of poverty, rapid and unplanned urban growth, the provision of services and infrastructure, development and HIV/AIDS. They include a range of civil society organisations - local, national and international non-governmental organisations (NGOs); financial services groups; trade associations; professional associations; religious organisations; community-based organisations (CBOs), particularly those supported by NGOs; the private sector; and bilateral and multilateral agencies.

NGOs in particular play a vital role in meeting a range of the livelihood needs of the city's low-income residents. However, currently there is no mechanism which would enable them to make informed decisions about the informal settlements in which to concentrate their efforts, to avoid overlap or duplication within some communities and neglect of others, nor to coordinate their initiatives with other groups.¹⁸ Indeed, an assessment of local service delivery within informal and peri-urban settlements in Kenya concluded that "A noticeable feature of NGO activities is that there is little coordination or collaboration between them." (Ogero, 2002).

Through supporting participatory approaches and capacity building initiatives, NGOs have helped to build and empower community-based organisations (CBOs), so that increasingly, various services such as community-based informal schools and water and sanitation facilities are being promoted by such groups themselves. However, although there has been an increasing trend towards the establishment of CBOs in the informal settlements, evidence shows that, without some initial support and capacity building from, say, an NGO, they are often weak institutions lacking leadership and organisational capacity and incapable of running activities on a sustainable basis.

In response to the impact of HIV/AIDS on those living and/or working in the city, many of these non-state actors are being proactive in this area - directly, through focused initiatives, or indirectly, through mainstreaming or integrating an approach to HIV/AIDS within their wider operations. One organisation of particular relevance to the current research is the

¹⁸ It is worth noting, however, that this vacuum may be filled by the Kenya Alliance of Resident Associations (KARA), which was established in 2005 as an apex body representing residents' associations, in order to achieve efficient and effective service delivery at the local authority level. Since its inception, KARA's membership has increased at a phenomenal pace and it has emerged as a strong advocate on governance, environment, security, water, land and judicial issues, as well as poverty reduction. It is also working towards forging sustainable partnerships with the government, private sector and like-minded bodies and persons.

Nairobi-based Kenya AIDS NGOs Consortium (KANCO), which was established in 1990 as a national network of NGOs, CBOs and religious organisations committed to HIV/AIDS prevention, care and support. KANCO's strategic goals include the provision of a competent secretariat capable of responding to its members' technical and HIV/AIDS information needs, establishing functioning national and district networks capable of providing regular forums for experience-sharing, and enhancing advocacy and technical capacity for its members to enable them to respond more effectively to HIV/AIDS issues.

4 The case study settlement

4.1 Location, origins and physical characteristics

The Mukuru kwa Njenga informal settlement is located approximately 18 kilometres from the city centre, close to the Nairobi-Mombasa highway (see Figure 1). It dates back to pre-Independence days, that is, before 1963. It is named after one of the first squatters in the area, which was a former sisal-growing farm.

The settlement has a generally degraded physical environment, with a poor drainage system, resulting in pools of stagnant water and periodic flooding. Water and sanitation facilities are few and those that exist are of poor quality. The physical infrastructure, especially the access roads within the settlement, is poor, making the transportation of goods and services difficult.

4.2 Political and administrative arrangements

In terms of political structure, the Mukuru kwa Njenga informal settlement falls within the Embakasi Constituency, which is represented at the national level by a Member of Parliament. The constituency comprises a number of *wards*, including Mukuru, each ward being represented by a councillor, who serves on the Nairobi City Council.

Administratively, the settlement equates with the Mukuru kwa Njenga *sub-location*, one of three which comprise the Mukuru kwa Njenga *location*. The latter, together with seven other locations (Umoja, Kariobangi South, Kayole, Embakasi, Dandora, Ruai and Njiru) make up the Embakasi *Division*.

As previously mentioned, the Mukuru kwa Njenga sub-location comprises a number of zones, those designated at the time of the fieldwork being the following seven: Vietnam, MCC, AA, Wapewape, Milimani, Sisal, and Forty-eight. Although not part of the formal administrative arrangements, most zones have a zonal committee comprised of a zonal chairman, who is a village elder, a lady representative, who is the zonal chairlady, and a youth leader. These are chosen by the residents under the supervision of the provincial administration, either the area district officer or the chief.

4.3 Stakeholder identification

A listing and brief description of the main stakeholders, which were identified as being active in the Mukuru kwa Njenga informal settlement as at August 2005, is presented in Annex 2. Stakeholders include those from civil society, government, and the private sector. The listing is based primarily on information obtained through an interview with the chairmen of the zonal committees.

4.4 Socio-demographic characteristics

Data extracted from the 1999 Population and Household Census for the slum enumeration areas tallied for the Mukuru kwa Njenga (MKN) sub-location indicate that the total population of the settlement in 1999 was 33,733, with 20,232 males (60%) and 13,541 females (40%). Table 4.1 provides a disaggregation of the 1999 male/female population by age group. Although data on the current population of the sub-location is not available, it is likely to have increased since 1999. The annual growth rate for slums in Kenya overall has been estimated at 5.9% (UN-HABITAT, 2006).

Table 4.1 Mukuru kwa Njenga Sub-Location: population by age group and sex, 1999

Sex	Age Groups													
	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	All Ages
Male	2,544	1,282	888	1,098	4,182	4,645	2,618	1,349	704	402	265	103	152	20,232
Female	2,433	1,388	936	1,433	3,408	2,270	813	393	180	100	52	39	96	13,541
Both Sexes	4,977	2,670	1,824	2,531	7,590	6,915	3,431	1,742	884	502	317	142	248	33,773

Source: Figures abstracted from census returns by the Central Bureau of Statistics, 2005

Table 4.1 shows that 28% of the sub-location's population was aged 14 years or below; this is slightly less than Nairobi as a whole (31%) and reinforces evidence from other sources that informal settlements have disproportionately few children. 46% of the total population were males aged 15-49, compared to 40% of the Nairobi population. While the number of boys and girls aged 14 and under were almost equal, and men far outnumbered women in all the age groups of above 20 years, rather surprisingly, the number of young women (aged 15-19) exceeded the number of young men. The modal age group was 25-29, and there were very few residents aged 50+ (2%).

Of the population aged 12 years and above, which totalled 25,371, 60% were married and 39% single. The number of households was estimated at 12,673, yielding an average household size of 2.7 persons. This is lower than the average household size in both urban areas as a whole (3.5) and the Nairobi slums (3.0). The World Bank 2004 study attributed the relatively small household size in informal settlements, in part, to the high proportion of single-person households, accounting for almost a third (32%) of all slum households (World Bank, 2006). By comparison, according to the 2003 KDHS, 23% of urban households in Kenya and 22% of Nairobi households are comprised of one household member (CBS et al, 2004).

With regard to educational achievement amongst the Mukuru kwa Njenga informal settlement residents, a breakdown of the male/female population aged five years and above by highest educational level completed is provided in Table 4.2. Men's educational levels were generally higher than women's: 37% of men and boys had completed primary school, 42% the first four years of secondary school, and 2% had higher levels of education, with 19% having an incomplete primary school or no education, compared to 41%, 17%, under 1% and 41% of women and girls respectively.

Table 4.2 Mukuru kwa Njenga Sub-Location: population 5 years and above by highest educational level completed and by sex, 1999

Sex	Highest educational level completed								Total
	Never+ NS/DK	Pre-Primary	Std 01 Incomplete	Std 01-04	Std 05-08	Form 1-4	Form 5-6	University+	
Male	737	491	86	2,116	6,558	7,333	206	161	17,688
Female	763	503	51	1,911	4,593	3,227	27	33	11,108
Both Sexes	1,500	994	137	4,027	11,151	10,560	233	194	28,796

Source: Figures abstracted from the 1999 census by the Central Bureau of Statistics, 2005

The extracted 1999 Census data also showed that nearly all the 12,673 households occupied their dwellings as tenants, almost all of whom rented from a private individual/landlord. Just over 950 were owner-occupiers (8%). 94% of the households lived in dwellings in which the dominant type of construction material used for the roofs was corrugated iron, while in 89% of cases, the walls and floors were made of mud/wood/cement and of cement/tiles/wood respectively. For 94% of households, the main source of water was a piped supply. A small percentage had to resort to a surface water source such as a river or stream. For the majority, the main sewage disposal system was the pit or bucket

latrine. A very limited number had access to a more formal sewerage system such as a sewer, septic tank, or cesspit.

4.5 Poverty

Since the calculations of the number of people living below the poverty line use data at the location level, obtained from the 1999 Census, it is not possible to provide an estimate of the number of poor people in the Mukuru kwa Njenga informal settlement or sub-location. It is likely, however, that the situation in the sub-location reflects that of the location of which it is a part, along with the two other sub-locations. Data on the Mukuru kwa Njenga location shows that, out of a population of 58,404, 26,895 or 46% were estimated to be living below the poverty line. The poverty gap, which shows how much poorer poor people are relative to the poverty line - that is, the depth of poverty, was 15.¹⁹

4.6 Household characteristics

The following describes the main household characteristics pertaining to the sample of 161 households surveyed for this study, which contained 629 household members. The household survey is complemented and supplemented with information from the focus group discussions (FGDs). Wherever possible, the life histories are used to amplify the findings from these two other sources. The 31 FGD participants were mainly 'self-selected' from amongst the sampled households, generating information which enabled further insights into the lives of the surveyed population. However, since the participants were expressing views beyond their own personal, household circumstances, the information so gained has also contributed to an understanding of the wider Mukuru kwa Njenga community of which they are a part.

The information pertaining to household characteristics has been analysed, and the findings structured, around the five livelihood assets. To the extent possible from the quantitative and qualitative data, conclusions have been drawn about the current status of these assets and their potential for use by households as part of their livelihood strategies.

4.6.1 Human capital

Socio-demographic characteristics

Table 4.3 Socio-demographic characteristics of the sample population

	N	%
Household size and composition		
Households (n)	161	
Household size (n)	3.7	
Single-person households (n, %)	17	12.0
Male-headed households (n, %)	142*	89.0
Female-headed households (n, %)	18*	11.0
Mean age of household head	37	
	%	%
Gender Profile		
	Male	Female
Age 0-4	55.0	45.0
Age 6-13	47.0	53.0
Age 14-17	46.0	54.0
Age 18+ (adults)	54.0	46.0
All individuals	53.0	47.0

Notes: *information was not available for one household

¹⁹ The poverty gap measures the poverty deficit of the population or the resources that would be needed to lift the poor out of poverty. It is expressed as a percentage of the poverty line, 15 representing the middle of the range used by CBS, which ranges from more than 30 to less than 5

Table 4.3 shows that there are more male household members than female in the sample population: approximately 53% compared with 47%. The age profile of the sample population is as follows: 25% are aged 0-5, 13% fall within the 6-13 age group, and 5% within the 14-17 age group, with 57% being aged 18+ (defined here as adults). This gives a ratio of 43:57 children to adults. The sample contained 250 children in total.

The average household size amongst the surveyed population is 3.7. This is well above the average for the settlement in 1999 (2.7), for Nairobi informal settlements in 2004 (3.0) and for urban Kenya as a whole in 2003 (3.5). It is considered that this reflects the survey's under-enumeration of single-person households, particularly single male households; this was related to the difficulty of contacting such households for the reasons outlined previously.

Household composition and structure

The overwhelming majority of the 161 households have a male head: 89% compared with 11% female-headed (compared to 18% in Nairobi as a whole, again probably reflecting the under-representation of single men amongst respondents). The mean age of household heads is 36.5. Just over 40% of the household heads are under the age of 30.

Aside from household heads (comprising nearly 30% of the sample), other members living in the households surveyed are spouse/partner (20%) and son and/or daughter (nearly 40%). Other relatives of the household head included sister and/or brother, niece and/or nephew, and granddaughter and/or grandson. Very few of the households contained any members who were unrelated to the head, presumably due to the restrictions imposed by single room dwellings (see Section 4.6.3).

Of those household members aged 14+, 64% were married. 85% of all male heads of household were married compared to 48% of the female household heads. It has to be noted, however, that there were only 17 female household heads, of whom 8 were married and 9 not married; indeed, 68% of all unmarried heads of household were male. 61% of all those who were married had a customary marriage, with 17% co-habiting or living with a partner but not considering themselves to be formally married. Only 9% had had a church wedding. Nearly all of those who were married/cohabiting had only been in that one relationship, which may be a potentially stabilising factor within the household unit. 88% of current spouses/partners live in the household; the remainder reside elsewhere, with over half (all female) living in rural areas. The picture that emerges, unlike the alarmist picture sometimes painted of widespread household breakdown in urban areas, is predominantly of stable nuclear households.

One of the outcomes of the HIV/AIDS epidemic is said to be an enormous increase in the number of orphans (children who have lost one or both parents), increasing the burden of child care for the remaining parent or other relatives. Respondents were asked whether the natural/real mother and father of the children in the sampled households were alive and living in the household. The widespread loss of parents/adult family members that more extreme pictures of the impact of HIV/AIDS predict is not obvious from the responses. The natural/real mother of 97% of children in the sample households and 85% of adults (18+) was reported to be still alive. Moreover, the natural/real mother of almost all (99%) the children (but only 34% of adults) is living in the household. The natural/real father of 88% of children, 46% of adults is still alive, with 96% of the former and 28% of the latter living in the household. The gender variation observed here appears to reflect the national situation with regard to mortality, that is, male mortality typically exceeds female mortality.

The survey findings suggest that, in line with typical residence patterns of Kenyan urban households, those mothers not living within the household mostly reside in a rural area - probably in the rural home of/with the extended family. By contrast those fathers not living in the household are working and are based elsewhere in the urban area.

Overall, about 70% of the households contain children or step-children (defined as individuals aged less than 18) who are living with their parents in the household. A range of reasons was given as to why the remaining third live away from the urban household, with the most significant being: to attend school, joining family/relatives elsewhere, poverty, and other family problems. In nearly all cases, a child living away from the urban household resides with relatives. 72% of those living away are aged less than 15, the mean age being 11 years.

In Kenyan society, it is expected that relatives' households will absorb and care for orphaned children. If adult HIV/AIDS-related deaths have increased, leaving children without one or both parents, it was expected that existing households would have taken in the children of deceased relatives. In addition, rural-urban migration data show that migrants are generally taken in by a relative's household while the migrant searches for work. Respondents were therefore asked whether their households had taken in new members during the five years prior to the survey. 44 households (27%) reported that they had taken in new members, nearly half of whom (20 of the newcomers) have remained with the household. Most came from rural areas, leaving their places of origin primarily because of poor job prospects. The existence of a family or relatives in Nairobi who could offer them accommodation was reported to constitute the main 'pull factor' for this type of newcomer. The reasons given for those who came to join the household but subsequently left mostly appear to be somewhat more transitory in nature. For instance, well over a quarter came just for a visit; a similar proportion left again because they either got married and moved in with their spouse/partner or they joined family/relatives elsewhere; with several more leaving to attend school. More of this type of newcomer were male than female. Of the newcomers aged less than 18, who constituted about three-quarters of all the newcomers, just under a third were orphans, the majority of whom had lost one parent. These six orphans were accommodated by four households (2.5% of the total). Thus, although caring for orphans undoubtedly strains the resources of those household who take them in, this does not appear to be a widespread practice amongst households in urban informal settlements, possibly because of the limited accommodation which most households can afford and the constraints on earning more if an income earner is already working full-time. In practice, as will be discussed below, orphans are much more likely to be sent to live with rural relatives.

In overall terms, the above findings indicate that relationships within most households display a relatively high degree of stability and permanence. Parental survivorship, particularly of mothers, is high; and most children live with their parents in the parental home. Furthermore, quite a number of the newcomers who came to join the household during the five years prior to the survey were still part of the household unit. Such households provide their members with an internal support mechanism on which they can rely when required. Furthermore, with the presence of the spouse of the household head in the household on a sustained basis may come a number of social, economic and health benefits, which can contribute to its overall wellbeing.

Migration history

Nearly all the household heads had moved to live in Nairobi from elsewhere - mainly from rural areas, most within the five years prior to the survey. By far the most frequent reason given for moving was poor job prospects; other significant reasons were to attend college/university/ vocational training, and as a result of being posted by an employer. Fewer than half the heads of households coming from outside the city had moved directly to Mukuru kwa Njenga. Most of these moved to the settlement from a variety of other informal settlements in Nairobi. Over half of the heads of household had moved house once or twice in the previous five years, with a good number having moved three times. The most frequently mentioned reasons for leaving their previous house fell into three main categories: housing, employment and affordability. Poor housing conditions relating to the structural state of the house, amenities, house size and the general environmental and security conditions of the immediate neighbourhood were cited by 36% of the respondents. Issues relating to employment, particularly distance to work places, loss of job and downturn in

business fortunes, were responsible for the movement of 27% of the respondents. About 12% of the respondents who had moved house reported that they had done so because they could not afford the rental costs of staying in their previous houses, because either the rent had increased or their own economic conditions deteriorated. For the remaining quarter of the respondents who had moved houses, a variety of reasons were cited, including getting married and moving to live with their spouses, seeking independence from their parents/relatives, loss of parents and eviction.

Thus although household composition appears to be relatively stable, households are mobile. The main reasons for mobility include rural-urban migration to seek work, moving between settlements and changing dwellings, both the latter due to the limited and unsatisfactory housing choices available to low income households. Some aspects of mobility may hinder the development of relationships between individual households, and others of strong ties with the wider population in a settlement - in other words, the formation of social capital.

Households' ethnic group

Ethnic ties may, on the other hand, provide a source of cohesion within a community. This may be the case in Mukuru kwa Njenga, where much the largest proportion of heads of household are Kambas (41%), with a good number of Kikuyus and Luhyas in roughly equal proportions, as shown in Table 4.4. The strong presence of Kambas reflects the historical development of the settlement.

Table 4.4 Ethnic group of household heads

Ethnic Group	%
Kamba	41.0
Luhya	13.0
Kikuyu	11.0
Luo	9.0
Kisii	8.0
Somali	5.0
Borana	3.0
Redile	1.0
Embu	1.0
Meru	1.0
Other	9.0

Educational levels

89% of adults 18+ in the sample reported that they could read and write. Over 90% had attended school. In 49% of cases, the highest level of school attended was secondary and for another 42% primary. Significantly more women than men fell into the latter group, with, concomitantly, significantly more men having reached the level of secondary schooling. The highest class completed for 25% was Standard 08; for 36% the highest class was Form 04. A sizeable proportion of adults are, therefore, relatively well educated. Over a third (35%) had also received further education and/or training: in 40% of cases, this was for one year (or less); for another 27%, two years; and, for 10%, three years.

133 children aged between 5 and 18 were attending school at the time of the survey, representing about 37% of the total number of children in the sampled population. The majority (61%) of these were attending primary school, though with a significant number (29%) receiving pre-school/nursery schooling. The majority (81%) attended day schools, either public/government or private schools, in roughly equal proportions, with a few going to religious day schools.

The average amount of fees that households containing children attending school paid per child for his/her education in the 12 months prior to the survey was KSh 3,856. From the information available, 19% of these households reported that they had paid nothing for school fees; 23% paid KSh 100<KSh 1,000; 41% KSh 1,000< KSh 5,000; 6% KSh 5,000<

KSh 10,000, and 10% KSh 10,000 and over. Few households get financial help with the cost of education. Of the few that did, half received help from the child/children's grandparents.

For some households, as shown in the analysis below, fees of the level noted above would clearly be a deterrent to sending their children to school.

Economic activity

Of the population aged 7+ (398 persons), over half had worked for money in the month preceding the survey. Nearly 40% of those working worked in full-time, waged employment, mainly in the private sector. Another 19% were in waged employment but were working fewer than 40 hours a week and/or for fewer than five days a week. Nearly a quarter of those working in the month prior to the survey worked as factory workers, with a significant number as traders or salesmen/ women, as shown in Table 4.5. The relative importance of these two types of work appears not to have changed when compared with five years prior to the survey. Few people had a second source of employment.

Table 4.5 Main type of work

Type of work	Number	% of those working
Factory work	49	24.0
Trading/selling	39	19.0
Transport work/driving	17	8.0
Skilled trade work	16	8.0
Construction (semi/unskilled)	14	7.0
Restaurant/bar/hotel work	7	3.0
Educational professional/ administration	5	3.0
Other professional/administration	3	2.0
Secretarial/clerical	3	2.0
Farming/Fishing	3	2.0
Health professional/ administration	2	1.0
Other	44	22.0
Total	202	100.0

For the 48% aged 7+ who reported that they had not worked for money in the month prior to the survey, 38% were looking after the house and family, while just over 30% were attending school. Approximately 24% of those not working were looking for work. Nearly all (98%) those who were not working but looking for work suggested that they were not working because 'no work exists' or that they 'can't find work'

The FGDs support these last two findings. Participants explained that, since there are few industries in the vicinity of the settlement, the opportunities for casual work - and, by extension, for permanent, waged jobs - are limited. Hence, people "only try their luck in Asian companies whereby they at times stay outside the companies for a whole day but get no job. They just go back home and lie on their beds without anything to do. This is to mean that there are no jobs". Casual jobs in companies are short-term; when the work is finished after a few days, those concerned "go back to the bad life", such as prostitution, since "there are no jobs here for people to do".

Three quarters (73%) of households relied on one wage earner only. Only one household was recorded as having no income earner. Nearly one-third of the households were recorded as relying on a self-employed worker.

Few people had had to stop working for money during the 12 months prior to the survey: "no work exists/can't find work" was the reason most commonly specified for giving up work, which implies that their former source of employment was no longer available to them. Given the difficulty in obtaining precise figures for household income, and the resource intensive methods needed to collect reliable data on expenditure, no attempt was made in

the survey to obtain figures for either, with the exception of wage earners. While the amount earned by those in wage or casual employment over the previous four weeks amongst the sampled household population in the settlement was reported to range from KSh 200 to KSh 77,800, the majority of earners earned KSh 6,000 or less (this can be compared to the 2004 poverty line of Ksh 3,174 per adult equivalent excluding rent). Further analysis of earnings shows that well over a half of wage earners had not paid any taxes on their earnings, with less than a quarter having paid taxes, while, in the case of the remaining one-fifth, a “don’t know” response was recorded. In only a very small number of cases (5% and 14% respectively) did these earnings either reflect the value of any in-kind payments such as food, or include amounts received in allowances, bonuses and tips. For a four-week period, in-kind payments were worth KSh 800 or less in 75% of cases; while the average amount received in allowances and so forth was KSh 2,500. Only about half of the waged working population had incurred expenditure on travel to work over the preceding four weeks - for many of them this was not more than KSh 1,000.

Three quarters (75%) of all workers had worked in excess of 40 hours in the previous week. Analysis by gender showed no significant differences between the number of hours worked by male and female household members with two exceptions: all of those who worked less than 10 hours were men, and more men than women worked between 10 and 19 hours. It was anticipated that one of the effects of ill health is a reduction in ability to work. Respondents were therefore asked whether the amount of work they had been able to do in the week prior to the survey was similar to the number of hours they normally worked. For just over 70% of workers, the hours worked in the previous seven days were the same as the number usually worked per week at their particular job, which was on average 55.6 hours per week. Discounting the high level of other, non-specified reasons (60%) given for not working the usual number of hours, illness within the household, which combined the response categories of own illness or illness of a family member, constituted the most commonly mentioned reason (approximately 11%) in this respect. Over the previous 12 months, the wage/casual workers surveyed had, on average, worked for 46 weeks. Over two-thirds of the workers had spent between one and five years doing a similar “sort of work”, which may coincide with length of time that they have been living in the settlement.

The findings indicate that when wage earners fall ill, they are generally not entitled to any sick leave entitlement nor do they receive any support from their employer for medical expenses for themselves or other family members.

Just under one-fifth of those who had earned money in the previous four weeks worked for themselves or in the family business. Of the 14 different types of business mentioned, vegetable selling and tailoring and dressing-making were by far the most common. Other significant businesses were selling other foodstuffs and household items, and hairdressing/beauty treatment/barber. In other words, the businesses fell within the informal sector, popularly known as *jua kali*.²⁰

Nearly all of these businesses were owned solely by the respective families, who had worked in excess of 40 hours in the previous seven days in running them. By far the majority (79%) of the business owners were male. The findings show that, over the previous five years, an increasing number of such businesses had been established, reflecting the trend in the country generally, and probably linked to the laying-off and retrenchment of employees in the formal sector. The businesses were situated in a number of different locations, but most commonly within the household’s plot (46%).

In nearly half of the cases, entrepreneurs reported that the amount of business carried out had gone down compared with five years previously. A range of reasons were offered as to

²⁰ *Jua kali*, meaning hot sun in Kiswahili, generally refers to petty trading, sale of second-hand goods, manufacture of metal goods, carpentry, etc, although some analysts prefer to restrict use of the term to manufacturing.

why this was so, with lack of money available to the owner to buy items to sell, lower demand for goods and services, and increased competition being most frequently mentioned. For the majority, the downward trend appears to have continued in the 12 months prior to the survey, again with lack of money and reduced demand being the main reasons cited. In only a few cases did entrepreneurs report that the volume of business had risen, with increased demand for the goods and services offered being the most important explanation. Business earnings were spent primarily on food and household items, rent, and stock.

The FGDs added some useful insights into the role of the *jua kali* sector in the settlement, as illustrated in Box 4.1.

Box 4.1 FGD participants' perceptions of the role of the *Jua Kali* sector in Mukuru kwa Njenga

It was the view of the FGD participants that, since it was difficult to find jobs in the formal employment sector, most people unable to find waged work, "indulge themselves in business" in the informal or *jua kali* sector.

They indicated, furthermore, that there was a wide range of opportunities available in the sector, including tailoring, juice-making, sorting coffee and/or French beans, washing clothes for payment (women), masonry, carpentry, welding, hawking, cooking and selling *mandazis* (cakes), cooking and selling *githeri* (maize and beans), selling charcoal, selling water (from City Council pipes or through illegal connections), selling vegetables, selling second-hand clothes (*mitumba*)²¹ other retailing, and running bars or saloons.

Participants felt that members of the community often preferred to be self-employed "instead of being outside company gates seeking jobs day in, day out" or because the pay from casual work "isn't fully sustainable" (meaning insufficient to sustain a household). Furthermore, in waged work, "you wait a whole month" to be paid and the pay is not sufficient, while "working for yourself, you work with the little that is available". On the other hand, waged employment meant that, at the end of the month, "you get something for your family". However, the general view was that "Getting a business is better since one can be sacked anytime if in employment".

It was also felt that self-employment was preferred *if* it is possible to access loans or credit. Indeed, when asked whether people in the community would prefer access to credit for income-earning activities or greater availability of formal job opportunities, most participants indicated the former. Obtaining credit, they believed, allowed one to start a small business and be successful: "If people can get micro-finance to start business they can lift their lives. If people can form groups like collecting garbage or manufacturing something, people can get jobs and be busy".

A number of tentative conclusions can be drawn from the findings on economic activity in Mukuru kwa Njenga. First, job opportunities in the formal sector are limited for residents of the settlement. Secondly, for those in employment in that sector, the work is often hard, with long working days, little time off and without any safety nets with regard to sickness, redundancy, and so forth. Linked to the first conclusion, it is apparent that there is a mismatch between the type of work available and educational level. Educational levels amongst the sampled population seem relatively high, but the type of work that people undertake, particularly in the formal, waged sector, does not make optimal use of their qualifications.

²¹ Restrictions seem to be placed on people who are involved in selling vegetables and selling second-hand clothes in that they reported that they are often "evicted" from the places where they set up their kiosks.

This conclusion is borne out by the findings from the FGDs, which indicated that few people amongst the population of Mukuru kwa Njenga were professional employees - there are only “a few teachers employed in pre-school and primary private schools” and no secondary teachers. According to the participants, this is not because people are uneducated but rather because there are no employment opportunities to match their education levels. Most of those who work as casual labourers, it was reported, are educated - “they are Form 4 leavers”. It was also considered that people “lack capital to do what they’ve been trained to do” and end up, for instance, selling *sukuma wiki* (vegetables).

Fourthly, it is the informal sector to which people increasingly look as their source of employment: while this is largely out of necessity, some benefits of being self-employed were also identified. Furthermore, in the view of the FGD participants, if micro-credit facilities were to be made available for income-generating activities in the *jua kali* sector, then self-employment would become a more viable option, particularly for the many young people in the settlement, whether holding good educational qualifications or not, for whom there are either no jobs or only poorly-paid ones. In the words of one mother: “I have a daughter who is working and she is paid between Ksh120 and Ksh180 per day. A loan would enable me start a business for her”.

Household carers

The main person in the household who was responsible for looking after the family in the week prior to the survey was, in nearly two-thirds of households, the spouse or partner of the head of household (101 persons). In most cases (86%), this person reported that he/she was able to carry out household activities on his/her own; backache and illness were the main reasons preventing the remaining carers from doing so.

Table 4.6 Relationship to head of main person looking after family

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Head	47	13.2	29.4	29.4
	Spouse/Partner	101	28.3	63.1	92.5
	Son/Daughter	3	.8	1.9	94.4
	Sister/Brother	3	.8	1.9	96.3
	Niece/Nephew	3	.8	1.9	98.1
	Other relative of head or spouse	1	.3	.6	98.8
	Unrelated	1	.3	.6	99.4
	Servant	1	.3	.6	100.0
	Total	160	44.8	100.0	
	Missing	System	197	55.2	
Total		357	100.0		

The survey sought to ascertain which household activities were concerned with medical care/sickness and how much time was devoted to them within the preceding seven days. 11% of main carers in the households had spent time caring for a sick member of the household – on average, 8½ hours during the preceding seven days. 7% of main carers reported that they had spent time seeking medical care, of which over a third had devoted two hours to this activity. Five of the main persons looking after a family (3%) had also helped relatives and/or neighbours with caring for a sick person, devoting an average of just over 3½ hours to this activity. Among the household carers, only one (a man) reported having also spent time away from their normal household activities attending funerals.

It is also relevant to note here that 38% of those aged 7+ who, it was ascertained, were not working, were looking after the house and family (76 persons), nearly all female household members.

Health

The following analysis deals with acute illness, disability and chronic illness, mortality and, finally, fertility, based on the household survey data, supplemented where relevant with information from the FGDs.

Data on acute illness show that many households (60%) had members who had been ill during the four weeks preceding the survey. In more than three-quarters of cases, the individuals reported only one illness episode. As can be seen from Table 4.6, a large majority of those individuals who had been ill fell within the 26-35 age bracket, followed by a quarter in the 19-25 age group. Of the household members who reported illness, more were male than female: 69% compared with 31%.

Table 4.7 Age of ill person

Age Group	Number	%
Under 5	11	8.0
5-10	6	4.0
11-18	4	3.0
19-25	34	25.0
26-35	55	41.0
35-50	20	15.0
Over 50	5	4.0
Total	135	100.0

Just under two-thirds of the illness episodes had started more than four weeks prior to the survey, with just over a third having started during the previous month. A few reported that their illness had started in the preceding five years. Most frequently, household members had been ill for between one and four days in the previous four weeks, although quite a few experienced a longer period of sickness of between seven and 28 days

What were the signs and symptoms of these illnesses? Most frequently mentioned as the most severe symptoms were acute fever, severe headache, and cough. Body weakness, vomiting, and chills were the second most commonly-mentioned set of severe symptoms. Chronic and acute diarrhoea, and recurring fever, were amongst a third set of severe symptoms mentioned by a few other people.²²

The findings indicate that an overwhelming majority of individuals (94%) had not sustained any injury in the four weeks preceding the survey. Amongst the few who had, fractures and wounds were the main types of injury sustained. Those who were affected by illness or injury were most commonly unable to carry on their normal activities for between one and three days, although a quarter stated that they had not been prevented from doing their normal tasks.

In three-quarters of the cases of illness or injury, someone had been consulted for treatment via a range of facilities. Overall, only a quarter of those concerned sought care first from a government hospital or clinic. Women's seeming reluctance to use such facilities as the first place consulted for treatment may well be related to their prior experiences, as will be discussed later. Roughly equal proportions (around 20%) of others first sought care from a mission/Islamic hospital or clinic, and a private for profit hospital or clinic, with a significant number (10%) going to a pharmacy. That the majority make use of non-state facilities confirms existing evidence that residents of informal settlements in Nairobi experience difficulties in accessing health services provided by either national or local government, in part at least because facilities are not located in the informal settlements.

²² While these symptoms (and others including weight loss and skin rashes) are typical of AIDS, as will be seen in the discussion below, the household survey did not produce any clear findings on the occurrence of HIV/AIDS in Mukuru kwa Njenga. Notwithstanding, such symptoms have been used as one criterion for the selection of households whose life histories were obtained, as explained in section 1 above.

Two thirds (65%) of the people concerned visited the respective facility only once – a fifth had visited it twice (22%). The overwhelming majority were treated as outpatients.

How much did households pay during the preceding four weeks for the treatment that the sick household member received? The total cost of treatment including medicine ranged from free to KSh 8,000, but the average cost was slightly under KSh 600. Most (nearly 80%) of the households, however, spent between KSh 100 and KSh 500.

Only a small proportion (about 10%) of individuals had sought care from a second establishment, predominantly from a private for-profit hospital/clinic. The total cost of treatment for the illness that had been incurred in the preceding four weeks ranged from KSh 500 to KSh 2,000. There was only one instance of a household member seeking care from a third source.

The overwhelming majority (93%) of those who were in wage employment did not have any of their medical care costs met by their employer. With the high level of poverty pertaining in Mukuru kwa Njenga informal settlement, what source of money was available to the households to pay for treatment/ medical care?

Table 4.8 Source of money for treatment

Source	%
Earnings	63.0
Savings	14.0
Borrowed	15.0
Gift/help from relative	5.0
Help from religious organisation	1.0
Other	3.0
Total	100.0

As Table 4.8 shows, two thirds of households financed treatment from the earnings of household members. Roughly equal proportions either used their savings or borrowed, with a very small number (5%) receiving help from relatives to finance their treatment. Those who found it necessary to borrow reported that in most cases, only small amounts were borrowed. An example of the “Other” category is help from the wider community, including politicians, as evidenced in one of the life history case studies.

Most (73%) of those who did not seek treatment for their illness from a medical facility or medical practitioner bought drugs from a shop. A few others (12%) did nothing about the illness at all, with the three following reasons in equal proportions being cited for this: the illness was mild, fear of side effects, and the high expected cost of treatment.

When respondents were asked whether their households had received any non-financial assistance to help them cope with illness, most responded in the negative. This apparent inability to access non-financial assistance may point to a weak local social capital base.

More than half of the illnesses and/or injuries were diagnosed by health professionals. Nearly half of the individuals were diagnosed as suffering an episode of malaria. As indicated previously, malaria constitutes the leading cause of morbidity in Kenya. Others were diagnosed as suffering from a variety of illnesses, including the common cold/throat infections, typhoid, respiratory problems other than tuberculosis (TB), and dental problems. Only one person was reported as having been diagnosed with HIV/AIDS²³. Malaria was also the most frequently-mentioned type of self-diagnosis (43%), with the common cold/throat infection being the next common ailment from which people thought they had suffered. Only two self-diagnoses of HIV/AIDS were reported. Respondents were also asked whether their illness had recurred, because those symptomatic illnesses associated with HIV/AIDS often

²³ Note that the respondent was generally the household head or his spouse. It is possible that individuals keep an HIV/AIDS diagnosis secret.

recur. A fifth (21%) reported that their illness had recurred between one and four times in the previous year and just under half (46%) were still suffering from the illness.

The findings show that very few households considered that they had a member with a major disability and very few (2%) contained members with long-term health problems. Because of people's reluctance to obtain an HIV/AIDS test or to admit their status, no direct question about their HIV status was asked. Instead, some of the recognised indirect approaches to ascertaining whether or not a respondent has HIV/AIDS were used, including ascertaining whether he/she had suffered from a long period of recurrent illness, and double checking morbidity responses associated with the opportunistic infections associated with the virus. Respondents were asked the date when a reported long-term illness had started, on the basis that full-blown AIDS typically takes around five years from the date of HIV infection to manifest itself. The few who considered that they had long-term health problems reported that the illness had, in most cases, started within the previous five years.

Amongst those with a long-term illness, there were very few instances of individuals having the symptoms associated with opportunistic infections typical of AIDS on a sustained basis, that is, diarrhoea for a month or more, recurring fever for a month or more, or loss of much weight in recent months. One person had had a rash in the past year. A variety of symptoms were experienced by ill persons as "most severe", including abdominal pains, breathing difficulties, acute diarrhoea, and severe headache, but these were difficult to associate with HIV/AIDS-related illnesses in particular.

The survey found that, in two thirds (65%) of the cases, health professionals had diagnosed the long-term health problems and that the professional diagnoses were very similar to those made by the sick persons themselves. One person reported that he had been diagnosed by a health professional as having TB, which is commonly associated with the HIV virus. Over half of those concerned had been visiting a health practitioner about their health problem - generally, two or three times in the previous six months, and had bought medicines once or twice during the same period. Fewer than half the households with members suffering chronic ill health had spent money on treatment, transport, medicines, and so forth, in the previous four weeks. Of these, the majority had spent between KSh 20 and KSh 800, with one person spending KSh 30,000. In all cases, the money came from one of the following sources: earnings, savings, or relatives.

What conclusions can be drawn from the findings above on ill-health in the sampled households, which may be applicable to the Mukuru kwa Njenga informal settlement as a whole? First, very few households contained members who were either suffering from long-term health problems or from a major disability, either of which could constitute a constraint on an individual's income-earning potential. What seems more pervasive is intermittent sickness or short-term illness, such as malaria, acute fever, severe headache, and coughs, which appear to affect most people periodically. Thus, many people are not completely healthy and have to function 'below par' - put another way, their human capital asset base is weakened, which can have a number of negative implications. For instance, those who are economically active may not be as productive as healthy people, which may affect their income-earning potential and may, ultimately, lead to termination of their employment. Similarly, those looking after the house/household members may be less active and effective in performing this task, with other tasks also suffering. Women, who often combine caring for the household and home with income-generating work, may be particularly adversely affected. Functioning below par can also constrain those who are actively seeking work. Thus people's ability to build up their financial capital base may also be weakened.

Furthermore, medical treatment is expensive: public health facilities, where the cost of treatment may be cheaper, are not readily available. Frequent visits to a health professional or clinic for treatment put a considerable strain on a household's income. Residents very rarely have recourse to safety networks such as a national health insurance scheme or employer medical cover; they have no or limited household savings; and borrowing from

relatives and friends via a household's social capital is not possible for many, since such networks either do not exist in the settlement or they are constrained by the general poverty situation therein.

No clear picture of the health status of the sampled households in the Muruku kwa Njenga settlement emerged from the survey. There were no definitive findings on, for example, the major diseases and health risks affecting people in the community, such as HIV/AIDS or TB. The sample was too small to provide a basis for estimating infant and child mortality and questions about deaths in the family did not indicate a dramatic increase in either child or adult deaths (see below). Stigmatisation of HIV/AIDS sufferers and lack of awareness, or reticence to talk about the disease may be some of the factors which limited the collection of information through the main survey instrument, the household survey. The focus group discussion and life history in-depth interview proved to be useful complementary data collection methods in this respect, providing some insights into these and other factors concerning the prevalence of HIV/AIDS in Mukuru kwa Njenga, as the following shows.

After some initial reticence on the part of the FGD participants to talk about the disease, the general view expressed was that HIV/AIDS was widespread in Mukuru kwa Njenga - "it's there". Box 4.2 contains the views of the participants when pressed to substantiate this belief.

Box 4.2 HIV/AIDS - hidden and invisible

The participants generally acknowledged that HIV/AIDS remained "invisible" in some respects - it was difficult to see "evidence" of it. For instance, people hide their status even though, by looking at someone, participants suggested that it was possible to see "signs that would enable you know he/she is infected with HIV/AIDS". Also "men...after knowing their status...don't disclose it to their wives and when the wives discover their HIV status they as well hide it from their husbands". Furthermore, "Anything to do with HIV/AIDS is so sensitive...disclosing that one is positive is a difficult thing to do." In other cases, it was suggested that, although some people have HIV/AIDS, since they do not visit Voluntary Counselling and Testing (VCT) centres, "they do not know about it". Others cannot believe they are infected so they "hide" their symptoms by associating their illness with witchcraft. Doctors contribute to this situation in that they test people but do not tell them directly that they are positive - "they say it is TB or pneumonia" and "hence, many people do not know they are suffering from HIV/AIDS". Another factor contributing to the invisibility of the problem is that sick people "are transported to the village to die there". Similarly, "when it is realised that it is AIDS, they are ferried home".

Reinforcing these statements, the view was also generally expressed that stigmatisation of disease sufferers was still quite common, as illustrated in the following cases: "My real brother, after sensing that I was HIV positive, asked me to leave his bed and sleep down on the floor. I slept on the floor for six weeks ...He couldn't use the same plate with me and couldn't eat any food I prepared". Another participant indicated that when an HIV/AIDS sufferer goes to their reserve (rural area), "he/she is not allowed to sit on a chair because it is known that before that person dies, he/she will be dirtying the environment around due to diarrhoea". However, there was some consensus that there is less stigmatisation nowadays than previously. For instance, respondents indicated that, in the past, it was said that "if you eat and drink with infected people you, too, would be infected. But nowadays it is not the case. You eat and drink with other people without discrimination". Another informant indicated that stigmatisation does not occur as much as it used to "since people attend seminars and are educated on how to take care of the HIV/AIDS sufferers. Thus we bring the sufferers near us".

Indeed, with regard to awareness, participants generally felt that people had knowledge of and information about HIV/AIDS, as the following views summarised in Box 4.3 indicate.

Box 4.3 Awareness of HIV/AIDS

Respondents claimed that, "You can't live a day without hearing about it", with awareness-raising being done through, for instance, the radio; "leaders in the church, primary and secondary school coming out to discuss the issue" or "ask[ing] couples to attend meetings where they discuss how it is spread, its effects and how to prevent it...in the workplace or in any group to which one belongs"; and frequent seminars and workshops, which, it is said, have made people understand that "the disease is no longer hidden". Through such means, people in the settlement have, it was suggested, become knowledgeable about HIV/AIDS, although there was some scepticism about whether people had assimilated this knowledge - "they hear but it's like they have no ears. They hear but don't change their behaviour".

Participants also felt that HIV/AIDS is discussed openly among members of the community, within the home and at school, although caveats to this were made. As one respondent explained, "I am an old man and I try to tell my wife and children"; while another stated that "I've a form two child and they are told at school". On the other hand, within the family, men "discuss it secretly with their spouses to avoid the children knowing about it". It was also thought to be unlikely that discussions take place in the village in the rural area. Whether discussion takes place also seems to be linked to status - thus, "those who discuss are the ones who have known of their status" or who have disclosed their status, and, in this respect, it was said, women are at the forefront: "they have come out openly for counselling in order to know their HIV status".

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The latter gender differentiation is worth noting since, in the opinion of some participants, women's greater responsiveness to the "call to visit VCT" had brought benefits to the wider community. Men, by comparison, "are ignorant and that is why we have the problem here at Mukuru kwa Njenga". Indeed, it was felt that if people went for testing, the problem of HIV/AIDS in the settlement might be reduced. However, it was also felt that people are afraid to go for VCT and to get to know their status.

Generally, it appears that the spread of knowledge about, and heightened awareness of, HIV/AIDS have contributed to a lessening of stigmatisation, which bears out the 2003 KDHS finding for Nairobi that a sizeable proportion (44%) of people expressed accepting attitudes toward HIV- and AIDS-infected persons (CBS et al, 2004).

The FGD participants also expressed their views about why they considered HIV/AIDS to be widespread in Mukuru kwa Njenga. Poor nutrition was seen as one reason for the spread of the disease, with body-building carbohydrates and energy-giving foods not being easily available. HIV can, it was suggested, also be caused by ill-health, resulting in reduced immunity. Both the latter reasons could be linked with poverty, which several of the participants considered had led to the prevalence of HIV/AIDS in this community. "Poverty has led to high transmission rate since people are straining to get money" through whatever means, since they are jobless. Girls were considered to be a particularly vulnerable group in this respect, often turning to prostitution in desperation.

The FGDs also identified which other diseases and health risks affect people in the community: there was general consensus that malaria, tuberculosis and typhoid were the most common illnesses. A strong link was made between these and the physical environment in which the residents of Mukuru kwa Njenga informal settlement live. Pools of stagnant water were reported to provide breeding grounds for mosquitoes. Dirty, untreated water or water that passes through places where there is sewage was associated by participants with typhoid. TB was linked to the cold, because people's dwellings are built of insubstantial materials. Other disease causing factors were thought to be the dumping of rubbish in an uncontrolled manner around the settlement, and dust within the area and coming from surrounding polluting industries.

Turning now to the household survey's findings on mortality, in view of the alarm over the effects of the HIV/AIDS epidemic as well as other illnesses, we anticipated that the incidence of bereavement would be noticeable and increasing. However, the occurrence of deaths in the five years prior to the survey amongst the sampled households was very low. Twelve households (8%) reported that a member had died, half of whom were men, half women. By way of comparison, the national adult mortality rates derived from the 2003 KDHS are marginally higher among females than males (6.6 and 6.2 per 1000 respectively). With regard to the relationship of the person who had died to the household head, only one was a spouse; half were sons or daughters; and the remainder were other relatives. Four out of the twelve who had died were adults aged 27 and above, but were not heads of household. Five were children aged six and below at the time of death (with two "don't knows" and one "no answer" in response to the question used to elicit this information.) Only three of the deceased were married or living with a partner at the time of passing away, but their spouses were not all present in the household at the time of death. Respondents reported that in only one case did the deceased's spouse/partner still live in the household. Three of the deceased people had children, with one having one child, another two and the other six, thus rendering nine children orphans. One household had the deceased member's orphans (three) currently living in the household.

When did the deaths occur and what were the causes? Of the ten cases for which information was available, death had occurred between 1997 and 2005. In most cases, an illness had been the cause of death, with a suicide and a fall accounting for two other instances. The most severe symptoms associated with the illnesses concerned were severe headache and chronic diarrhoea (but not for a month or more prior to death). The next most severe symptoms were acute fever, weakness, and chills. Recurring fever and vomiting were also recorded as symptoms. Two of the deceased people had experienced major weight loss before death

In the majority of the cases of mortality, outpatient treatment had previously been sought, primarily at a municipal/government hospital or clinic. In other cases, treatment had been sought at a mission and/or private hospital or clinic. The amount paid for the treatment, medicines, and so forth ranged from KSh 20 to KSh 1,800, although in two cases, KSh 12,000 was paid. Where treatment was sought from a second and a third outpatient facility/practitioner, perhaps reflecting a deteriorating state of health, quite considerable, additional costs were incurred. Indeed, about half of the deceased were hospitalised for the condition that led to his/her death. The different amounts paid for this were respectively: KSh 1,000, KSh 6,000 and KSh 12,000.

The total cost of treatment of the condition that led to a person's death ranged from KSh 500 to KSh 105,000, a household member's earnings being the main source of payment. This must have placed a heavy financial burden on the households concerned, whose income levels are low. No one borrowed to meet the costs.

Fewer than half of the households concerned had received financial assistance to cope with the deceased's illness. Those that did had received help from a Christian church/Christian organisations and community-based organisations, assistance that was used for buying drugs etc.

Nearly all the illnesses leading to the deaths had been diagnosed by a health professional. The illnesses diagnosed most often were malaria and TB. Asthma, typhoid, and respiratory complaints other than TB constituted other diagnoses. Quite a number of the respondents also diagnosed malaria as the most significant illness from which the deceased had suffered and which had led to death; others mentioned TB, typhoid, and/or a throat infection and, in one instance, witchcraft.

Nearly all the deceased had been buried in a rural area, a strong indication that urban residents maintain strong ties and links with their rural kin/areas of origin.²⁴ The cost of a deceased person's funeral ranged from KSh 2,000 to KSh 25,000. Some households received help with such costs from people outside the household.

In summary, the occurrence of deaths in the past five years amongst the sampled households has been very low.²⁵ To a considerable extent, the type of illnesses which contributed to the deaths is mirrored by those which are extant now and which regularly affect current residents. The costs of treatment for those who had become terminally ill were considerable; as are funeral and burial expenses. None of the deaths recorded were stated to be specifically caused by AIDS; and it is difficult to attribute any of them to AIDS from the information provided on symptoms of the preceding illness. However, some of them may have been caused by illnesses symptomatic of the disease.

One further indication of deaths caused by HIV/AIDS is the presence of orphans in the community. Although, as indicated above, nine orphans were living in the sample households at the time of the survey, it was not possible to be sure that they were 'HIV/AIDS orphans'.

Nonetheless, both the FGD participants and the life history cases revealed that children who have been orphaned as a result of HIV/AIDS are considered to be a problem in Mukuru kwa Njenga, although it is difficult to gauge from the discussions how large an issue this is. Some of the participants reported that they found it difficult to know who was an orphan, although they considered that children who were malnourished and not well dressed often fell into this category. In other cases, knowledge of who was an orphan came through personal experience - that is, where some of the female participants were helping to look after the child/children of a dead relative or friend. But, in the view of others, orphans are "usually taken to their relatives back at home in the rural areas". The latter is another reason why it is not easy to judge the scale of the problem: when a sufferer dies, his/her children are taken to their rural home - "the children don't remain in town since they've nobody to take care of them".

Nevertheless, the presence of orphans in households in Mukuru kwa Njenga provides evidence of the impact of deaths, including HIV/AIDS-related deaths, on households. Boxes 4.4 and 4.5 illustrate how two affected households cope with this.²⁶

Box 4.4 An orphan in James' life : coping with the impact of HIV/AIDS

James, a 28-year old single man, earns his living as a barber. He reported that he does not earn much from his work but said that he is able to survive on his earnings: "I can work for KSh 80 in a day, which is enough to buy milk, *unga* and then pay KSh 30 to charge the battery of my hair-clippers".

With the death of his sister and brother-in-law, James has taken on the responsibility of caring for their son. James explained how his life has changed as a result of this. "The child is putting a heavy burden on me. I could sometimes do without lunch or even breakfast but now I can't. Sometimes I could eat at friends if had no money, but now I must have food in the house because of this child. I have had to borrow money from '*mashabiki*' (friends) to make sure there is something for the child to eat. Now I have to borrow 'twice' - for charging the battery and for food."

²⁴ Urban-rural linkages are discussed further in a separate sub-section below.

²⁵ Households in which both adults had died, or where a remaining spouse had returned to the rural areas to live, were, of course, excluded from the sample.

²⁶ In both cases, the names of the individuals concerned have been altered to protect their privacy.

Another aspect of James' changed financial situation concerns savings. "I used to save, say, KSh 100, but now I have nothing since I started looking after the boy. I can't save anything."

What else has changed in James' life? The death of his sister has forced him to take on a new role -parenting. "You see... he is a child and I have to do everything for him, I have to wash his clothes and cook for him. When he is playing, his clothes get dirty but I can't tell him not to play with other children. If I stop him, my friends and other people will blame me and say, look, he is mistreating his nephew and say that I'm not taking good care of my sister's son."

After the death of his sister and her husband, the boy was withdrawn from the government primary school he was attending in Dandora. In Mukuru kwa Njenga, there are no public schools and "I cannot afford a private school." "Schools here would cost about KSh 1,000 a term; where will I get that money from? I will take him to the rural area." Currently, James is looking for money to buy his nephew a school uniform and bus fare to take him home.

Sending the nephew to the rural home will have further implications for James. "It will now force me to visit my rural home frequently to know how he is doing. Previously I could stay for more than two months without going home but now I will have to go home every month."

James' social life is also affected. He is unmarried and has no immediate plans to marry. "I would rather wait for a while... I do not know how long. Although I was intending to marry soon, things have changed now, marriage will have to wait." The fear of a would-be wife mistreating his nephew was one reason that he gave for delaying marriage.

There are no other relatives who help to bring up the child. "They don't bother and I would not want my nephew to be a *chokora* (street boy)."

For those looking after HIV/AIDS orphans within the settlement, ensuring the continuation of their education, particularly after Standard 8, is a problem because of the costs - even if they can get access to "free" primary school education.

The second case is about a female, single head of household.

Box 4.5 Anne's life with orphans : coping with the impact of HIV/AIDS

Anne takes care of seven grandchildren, five of whom are HIV/AIDS orphans. Three of these are the children of her late son and two of her late daughter. Anne also looks after her late son's wife, who since his death has had two more children.

Various charitable organisations have provided support to Anne. World Vision provided resources to enable the children to attend school within Mukuru kwa Njenga, for example, school uniforms. It also helped Anne to set up a small business - cooking and selling chips - by providing two gallons of oil worth, cooking utensils and other items, worth in total KSh 5,000. One of the reasons she chose this line of business was that it allowed the children and her to eat some of the chips produced.

Other groups include the Highlands Community Assistance Programme. Local community leaders also help.

During school holidays, Anne sends her grandchildren and daughter-in-law to her brother, who lives in a rural area. This gives her an opportunity to renew her energy and make some savings. This year it also allowed her to recover from an accident when she was cooking chips which resulted in her being badly burned. Because she had nowhere else to undertake her business, she had been cooking the chips within the confines of the household's dwelling.

As a result of this accident, Anne's business collapsed and at the time of the interview, she had no income. She also reported that she had fallen behind with paying her rent. She was looking for other, less risky income-generating activities (IGA): the options she identified included buying and selling charcoal, and selling potatoes.

Anne said that if the children had the option to go to a boarding school, she would go back to her rural home, where she still has land, and farm. She also said that, if she owned the dwelling she lived in, then life would be more bearable. In Anne's words, "It is tough, but I'll take care of my grandchildren and educate them so that they can help me in the future."

Turning to fertility, the findings of the household survey show that the majority (81%) of the 137 females aged 14 and over within the household sample population had given birth. Three-quarters had given birth to between one and three children, with significant numbers having had four or five children (10% and 8% respectively) and, in two cases, 10 children. In total, the women in the sample population had given birth to 136 children. There were slightly more male births than female. Only a few of these children have yet reached adulthood, with about three-quarters presently aged 10 and below, suggesting that there are many young families within the settlement with children who do not contribute to the household income. A large proportion of the children born to the women in the sample are still living in their households. 31 children were reported to have died, constituting 23% of those born, which is a higher rate than the average for Nairobi. The three main causes of death were acute diarrhoea, vomiting, and childbirth problems. Breathing difficulties and weakness were mentioned in the case of another two deaths.

The overwhelming majority (88%) of women had attended an antenatal clinic during pregnancy. However, home was the most common place for delivery (40%), with a significant number (28%) of other mothers delivering in a government/municipal hospital or clinic. The rest delivered, in roughly equal proportions, in a private for-profit hospital or clinic; a mission/ Islamic hospital or clinic; a community clinic; and with the assistance of a traditional birth attendant (TBA). The survey found that about half the births had been assisted by a doctor or a nurse. TBAs were the second most important category (30%) of those who assisted, with a friend or relative being the next most significant (16%). A few women had delivered without any assistance. Various reasons were given for the choice of delivery place, the most significant ones being that the facility was cheap or free, or it was considered safe. Affordability, a trusted practitioner or good quality service, and a familiar, warm social environment were amongst other reasons given. Whatever delivery arrangement, most mothers (85%) reported that they were healthy during pregnancy, and that nearly all their babies (93%) were healthy at birth.

These findings largely reflect the norm in other parts of the country, especially rural areas, in that many women attend antenatal clinics but they deliver elsewhere, either with the assistance of a TBA, relatives and/or neighbours, or without any assistance. This is in part due to the inaccessibility of public health facilities and their inadequacy both in terms of the infrastructure - physically run-down, dirty, poorly equipped, and so forth - and of the quality of service provided, with insufficient personnel, their "don't care" attitude and so on. In other words, in the absence of public health provision or in the light of inadequacies in that provision, women's coping strategy at the time of delivery is either to go 'private' or to deliver without any assistance.

Thirteen of the females aged 14 and above (7%) were recorded as being pregnant at the time of the survey. Nearly three-quarters of those not pregnant were not currently using contraception. Where their reasons for not using contraception were specified, not being sexually active and wanting another child were the most frequently mentioned. In a few other cases, it was evident that a woman's partner refused to allow use of a contraceptive method.

Of the female members of the households aged over 14 who were using contraceptives at the time of the survey, an injection was by far the most common method (68%) recorded, followed by the pill (25%). Only a small proportion (12%) of the women's partners were reported to normally use a condom.

Respondents' views on whether they or other members of their household were generally satisfied with various public health services used in the previous year were also elicited. However, the findings have to be used with caution, as analysis of the data shows that it was not always clear whether respondents had actually made use of the facilities on which they commented in that time. The responses showed that 50% of the respondents were satisfied with government outpatient services, while 45% were dissatisfied, with the remainder giving a "don't know" response. Reasons given for dissatisfaction fell into two categories viz. facility-based and service provider-based. With regard to the former, people were dissatisfied because of filthy or unclean facilities, inadequate facilities, congestion, and unavailability of medicines. Reasons associated with service providers included corruption, unfriendly or rude staff, poor service with lax or slow staff, and the "don't care" attitude of staff.

Furthermore, a large proportion (40%) was not satisfied with government in-patient hospital services, although a smaller proportion (28%) was²⁷. The explanations for dissatisfaction were similar to those concerning outpatient services. Facility-based explanations included congestion, overcrowding, insufficient facilities, and lack of essentials e.g. medicines and water; while those associated with service providers comprised unfriendly staff, arrogant staff, poor service, a "don't care" attitude, inadequate attention, and discrimination.

With regard to government facilities that the adult women in the household might have used for delivery, 36% had not used government delivery facilities, and of those who had, 43% were satisfied and 45% were not, with the remainder not expressing an opinion. The multiplicity of reasons explaining why there was dissatisfaction can be classified into the two same categories. Congestion, inadequate facilities, poor facilities such as poorly ventilated rooms, and absence of equipment were all mentioned as facility-based problems. However, it is evident that the main cause of dissatisfaction with delivery is related to service provider concerns such as unfriendly, uncaring and arrogant staff; harassment from nurses; poor services, such as staff not attending to patients on time or simply not committed to their work; frequent strikes by health personnel, especially nurses; and hasty caesarean section operations.

Slightly more women were satisfied with antenatal and childcare facilities than dissatisfied. Facility-based reasons for dissatisfaction similar to those above were cited, such as inadequate and under-equipped facilities, while those related to service providers included negligence by health care staff, especially nurses, ineffective immunisation, unfriendly staff, and poor service, although also mentioned was the lack of education on the prevention of mother-to-child transmission (PMTCT). Lack of knowledge and unavailability of information about PMTCT may well explain why 73% of the sampled household heads, who are primarily men, and 69% of their spouses or partners reported that they had not had an HIV/AIDS test.²⁸ Indeed, information from the FGDs indicates that HIV/AIDS-related services in the settlement are generally inadequate.

Wealth and well-being

The survey sought to ascertain households' perceptions of their relative wealth/poverty, based on a number of criteria,²⁹ and whether these were different when compared with five

²⁷ We know from other data that 28% of households had actually used in-patient facilities in the previous year.

²⁸ This finding is at slight variance to the FGD information obtained on this, as referred to previously, which suggested that female members of the community were more predisposed to use VCT facilities.

²⁹ As covered in the definition of absolute poverty, that is, "not having the basics to sustain human life: enough food to eat, clothes to wear and shelter".

years prior to the survey. First, how did the households rate themselves in terms of their overall 'well-being' relative to other households in the community? By far the largest number (61%) felt they were just about average, with roughly equal proportions (about 15%) rating themselves as either a little poorer than the rest, or among the poorest in the community. Only seven of the households felt that they were among the poorest in Mukuru kwa Njenga. Three others ranked themselves at the "rich end" of the spectrum, with one household saying it was the richest in the community, another considering itself to be amongst the richest, and the third as richer than most households in the area.

How did these rankings compare with five years ago? A significant number of the households, though fewer than at the time of the survey, described themselves as about average at that time (2000). Correspondingly, a larger number - 12 households compared with three at the time of the survey - rated themselves at the richer end of the spectrum, with nine households describing themselves as richer than most others in the community, two as among the richest, and one as the richest. So, too, did a slightly larger number in total than at the time of the survey rank themselves at the poorer end of the spectrum viz. 29 as a little poorer than most households, 16 as among the poorest in community and 11 as the poorest in the community. In other words, no clear pattern emerged with regard to households' well-being compared with five years ago: for some households, life has improved, while for others, life appears to have got worse.

Table 4.9 Self-rating of household relative well-being 5 years prior to the

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	The richest in the community	1	.3	.6	.6
	Among the richest in the community	2	.6	1.3	1.9
	Richer than most households in the community	9	2.8	5.7	7.5
	About average	74	23.2	46.5	54.1
	A little poorer than most households in the community	29	9.1	18.2	72.3
	Among the poorest households in the community	16	5.0	10.1	82.4
	The poorest in this community	11	3.4	6.9	89.3
	Can't tell	17	5.3	10.7	100.0
	Total	159	49.8	100.0	
Missing	System	160	50.2		
Total		319	100.0		

Another criterion of well-being used was the self-assessed adequacy of household income. In terms of the adequacy of total household income over the month prior to the survey, the majority - 70% - felt that it was not adequate, with the remainder considering it "just adequate". Comparing their current situation with that of five years previously, a quarter of the households considered their total income was the same as before. The proportion of those expressing the view that their income was "worse now" (both "a little worse" and "much worse") was larger than those households describing it as "better now" (both "a little better" and "much better"). Quite a few households indicated that they could not tell or did not know.

It is clear from other work on household livelihoods that insecurity has a major influence on people's well-being, with shocks (especially illness or death) and stresses often being the

trigger for impoverishment. Conversely, it is clear that increased security is a higher priority for many households than an increased income per se. Survey households were asked about their experience of good fortunes or shocks in the five years prior to the survey, anticipating that these might be related to a change in their income or wider well-being. Further information on these two variables is provided below.

Another aspect of wellbeing is a household's nutritional status or the adequacy of its food consumption. Thus, the survey sought to know whether households had access to staple foods such as maize meal; vegetables; fruit; pulses/beans; and animal products, including dairy products, fish, eggs and meat. First, 59% of the households reported that they had consumed sufficient staple foods in the 12 months prior to the survey, with some 64 households (41%) reporting that they had suffered a shortage. A lesser proportion of households (29%) reported that they had suffered a shortage of vegetables. Nearly half of the sampled households indicated that they had not gone short of fruit. This finding was somewhat unexpected as fruit, although readily available throughout most of the year, is not generally a significant part of Kenyans' regular dietary intake. Although over half had suffered a shortage of vegetable protein, a large minority had not.

Relatively fewer households (30%) reported that they had suffered a shortage of staple food five years prior to the survey, but access to vegetables during the year of 2000 was worse for relatively more households. Conversely, well over half (58%) of the households did not suffer a fruit shortage then; fewer households also went without vegetable protein.

Table 4.10 Consumption of food items by average number of days a week in the previous month and the year 2000

Average number of days a week	Vegetable	Fruit	Vegetable Protein	Meat	Other Animal Protein	Tea/ Coffee
Previous month	5.28	2.66	2.26	1.74	2.54	5.67
2000	6.12	4.29	4.10	3.53	4.31	6.25

As Table 4.10 shows, when compared with five years prior to the survey, it was evident that the average number of days households consumed the respective food items had decreased. Nevertheless, with regard to food consumption over the month prior to the survey, the majority (57%) of households considered that this had been adequate, although for a significant proportion (42%) this was not the case. A surprisingly large proportion of these poor households (63%) had, on average, consumed three cooked meals per day over the previous one week; while a further third (30%) had had two cooked meals per day. However, about 8% had only eaten one cooked meal a day on average, typically comprising vegetables, most likely kale (*sukuma wiki*) and maize meal known as *ugali*. The latter mixed with beans - *githeri* - would make up another common meal, reinforcing the finding that households ate vegetables/plants on average 5.28 days a week. Very few people in the settlement can afford to eat meat as part of their diet.

A further indicator of poverty is whether people have enough clothes to wear. The survey revealed that slightly more households felt that their clothing was adequate than those who considered it inadequate.

Do households have money available to buy items other than food? Overall, the majority (89%) of households had members who had spent money on toiletries, services or entertainment in the four weeks prior to the survey. A significant number (70%) had spent money on toiletries, in amounts ranging from KSh 20 to KSh 3,000, with a mean expenditure of KSh 319. But well over a quarter of the households had not spend money on toiletries.

Nearly three-quarters of household members had spent money on personal services, such as a haircut, a shave or hair/beauty treatment, with amounts ranging from KSh 10 to KSh

2,000. The mean expenditure on personal services was about KSh 186, although expenditures of KSh 20, KSh 40 and KSh 100 were the most frequently mentioned amounts. About a quarter had not spent any money on personal services in the previous four weeks.

Taking these two sets of findings together, it can be seen that, for a quarter of households, there is no spare cash for anything other than food. That fewer household members than was the case with respect to either toiletries or personal services spent money on entertainment in the four weeks prior to the survey (28%) lends weight to the latter point. The average total amount spent on entertainment was higher than the other two types of expenditure - KSh 541, although for many household members expenditure was only KSh 100. But the majority (69%) spent nothing on entertainment, indicative perhaps that there was no money to spare for luxuries. Indeed, it can be concluded that, beyond food, household expenditure is generally restricted, with the exception of generally small amounts of money being spent on the purchase of toiletries and personal services.

Fortunes and shocks

Less than a quarter of the households reported that they had had any significant good fortune in the five years prior to the survey, primarily in the form of an inheritance. A substantial gift from a relative was mentioned in a few other cases.

In contrast, over half of the households had experienced shocks or unexpected events in the previous five years, which had led to a reduction in their assets, consumption or income. A range of shocks was experienced, but death of a household member, loss of employment through retrenchment and severe or long-term illness of a household member stand out as the major types.

More generally, it is the daily stresses of living in the settlement with which people have to cope. Box 4.6 describes how a divorced female head of household deals with both shocks and daily stresses.³⁰

Box 4.6 Joanne's experiences : coping with shocks and stresses

Joanne was 48 years old at the time of the interview and reported that she had been divorced twice. She was taking care of her own five children, the first-born being 28 years old and the youngest 14, her three grandchildren and a niece, who was the daughter of her late sister. They were all members of her household.

In 2003, her house was burnt down and she was severely injured - nearly all her body was burnt as she tried to save her grandchildren. As a result, she was incapacitated and had to stop working, that is, selling scrap metal and used plastics, which was the source of her livelihood. Secondly, she required skin grafts and thereafter constant medication.

Joanne has had to cope with another shock. In 2004, her daughter, who had been supporting the family, was jailed in connection with the murder of a man. "My daughter used to help me more than my son. She was very good - if she were here, we would not be suffering as much."

Another effect of her changed financial situation is that her third-born child has dropped out of secondary school, leaving the girl vulnerable to the social and health conditions characterising the environment within the informal settlement.

A further stress is that her other children have no work. For instance, her first-born son "has no job...he only goes to the *matatu* (public minibus) stage to see if he can find some tout work, to see if he can find something to do. It depends on who you know. But nothing comes out of this." Sometimes he goes to the industrial area where he sometimes finds

³⁰ The name of the individual concerned has been altered to protect her privacy.

work. But “It is hard to find work. It is only construction work, which pays very little. You can be paid KSh 140 per day, sometimes KSh 150 or even KSh 170 if you are lucky.”

Another stress which Joanne has had to deal with was the fear that she might have had HIV/AIDS since, at one stage, she had boils all over her body, which she knew from her prior knowledge are associated with the illness. To allay this fear, she took action: “I even went to a VCT for an HIV test. The results were negative.”

The options open to Joanne to deal with ongoing stresses appear few, but she has found some opportunities. For instance, by managing to prevent her former husband from selling off the house in which she was living, she does not pay rent. Furthermore, she has found alternative accommodation provided by a neighbour for her elder sons: this relieves some of the pressure on the sleeping space in her house.

For Joanne, “Life changed after the accident. We are all suffering now. I want to trade in *mitumba* (second-hand clothes) or sell vegetables. If I can get support to start a business, I can help my grandchildren.”

4.6.2 Financial capital

Income and expenditure

The above findings show that a large proportion of the households (70%) considered their monthly income inadequate. Items of expenditure such as those mentioned above - food, education/schooling, medical expenses, toiletries/services/entertainment, as well as others, including rent, water, kerosene, and rubbish disposal,³¹ would normally be expected to be covered by income but, given the former finding, how valid is this in Mukuru kwa Njenga? By way of illustration, the source of money for medical treatment for many households (63%) was earnings but, for others, treatment was financed either through borrowing (15%) or from savings (13%). The following first provides more details about savings and credit, as means by which a household can enhance its financial capital.

Savings

The findings show that the majority of households (62%) had no member with any savings, suggesting that most households in the Mukuru kwa Njenga informal settlement had a weak financial base. Of the third of households which had members who saved (34%), about three-quarters saved in a merry-go-round (MGR) (a form of rotating savings association), which was their first-choice savings institution. A MGR enables members to take turns in receiving an accumulated amount of money built up over a period of time through the savings of each individual contributor. A savings and credit union was the second preferred institution, with a bank and the home being the third and fourth choice of saving institution.

Of those who saved, only half received any interest on their savings, albeit with minimal amounts being earned in the previous 12 months. In two-thirds of the cases, the interest earned was not more than KSh 1,000, but interest was as little as KSh 50 in some instances. The findings show that the savers had withdrawn money from their savings fund once or twice in the previous 12 months.

The majority of people have small amounts of savings. Two thirds (64%) reported that they had accumulated a current total savings fund of less than KSh 10,000, although the amount ranged from KSh 200 to over KSh 1 million.

Few household members, it appeared, had saved anything in the previous four weeks, and when they had been able to do so, the amounts were less than KSh 1,000, although they ranged between KSh 20 and KSh 5,000. Again, with respect to savings made in this latter

³¹ As described under *Physical capital* below.

period, MGRs emerge as by far the most preferred savings institution, perhaps because they match the purposes for which people save. It is evident that those who saved did so for a particular purpose, which was, overwhelmingly, to meet household expenses. In some cases, however, MGRs restrict the items on which members can spend their savings. Other main purposes for saving included: medical expenses, to purchase land or for one's old age; none of the interviewed households mentioned education of their children as one of the reasons.

A larger proportion of people (38%) reported that they were saving less than they were five years previously than those able to save more (29%). For a few others (16%), the amount they saved remained the same over the period. Reasons for the change in the amount saved were varied: for those saving less at the time of the survey, they included increased social/family commitments; economic hardship; additional household members; increased expenses/cost of living, and more financial responsibilities. Those able to save more at the time of the survey attributed this to having more than one source of income, receiving a salary increment and improved ability to save. Others were saving more because they wanted to invest.

Overall, it can be concluded that saving as one way of building a household's financial capital is either not an option available to, or is not being utilised by, most of the sampled households. This may imply that, after all the various items of expenditure identified by the survey are made, there is no spare money available to put by as savings. Even for the third of households that do save, it is evident that the main purpose for doing so is to cover household expenses. Not surprisingly, the MGR represents a popular form of savings institution for the poor living in informal settlements, such as Mukuru kwa Njenga, since it can be used to meet this very specific, vital need. However, it is evident that, in some cases, MGRs set conditions specifying what items its members can spend their money on.

Credit

Accessing credit is another way of enhancing one's financial capital. What were the findings of the household survey in this respect? It was evident that most of the households (64%) had not borrowed any money in the previous three months. However, a third (33%) had done so. Where money had been borrowed from an organisation, the main source was a credit/cooperative union. Of those who did not borrow from an organisation, the majority (88%) had borrowed from a person, many (66%) of whom were not relatives. In most other cases (32%), the lender and borrowers were related by blood. This suggests that kin and social networks play an important role in resource mobilisation and access to credit.

The household survey showed that, overall, the majority of the lenders (80%) had obtained their largest loans comparatively recently, that is, less than three months prior to the survey. Generally, such loans involved small amounts of money, with the majority (86%) of the borrowers borrowing KSh 5,000 or less, and one person having borrowed as little as KSh 50. The highest amount borrowed was KSh 100,000, which applied in two cases. With respect to the largest loan, if more than one had been taken, over 70% of the decisions to take this loan had been made by the household heads, with the spouse/partner accounting for most of the remainder. Similarly, the decision on the use of the loan was largely made by the household head - in two-thirds of the cases. Spouses/partners made such decisions in only about a third of the cases. Thus, in a situation where the overwhelming majority (89%) of the household heads are men, not only were opportunities for women to access financial capital limited, but they also appear to have little control or say over the use of borrowed money.

Notwithstanding this, household expenses were the most frequently mentioned use to which the loan was put, followed by others' medical expenses. To invest in business or to meet education costs were the next most common uses for which the loans were obtained.

The terms of borrowing appeared relatively favourable, since more than half of the borrowers were not required to repay their (largest) loan as a lump sum but were repaying it in

instalments. Half were paying on a monthly basis, with a significant number of other borrowers (32%) allowed to make the loan re-payments occasionally - less regularly. Not surprisingly, the overwhelming majority (80%) of persons providing money to repay the loans were household heads. Spouses/partners did so in only 14% of cases. Thus, within the family unit, it appears that the borrowing and management of large loans are primarily the responsibility of the household head.

While a good number of the borrowers reported that they were up-to-date with repayments (55%), a significant number (43%) were not. A range of reasons for not being so was mentioned. While lack of money constituted the main reason, most of the others also concerned people's financial situation, viz. husband not paid well, no regular income, other financial commitments, will pay when get a job, and too many household expenses.

Few households contained a member who had obtained a loan more than three months previously that was still outstanding. Again, in only a third of these cases had the current loan been obtained from an organisation - such as a microfinance NGO, other type of NGO, a religious organisation, or a credit union/cooperative society. Three-quarters of the loans had been obtained from a person, who was unrelated to the borrower in the majority of cases. A total of over two-thirds of the loans had been taken relatively recently - that is, within the eight months prior to the survey. Most (over 60%) of the loans were small amounts of less than KSh 5,000.

Similar to the finding above, in 39% of cases, the outstanding loan was to meet household expenses. But an equal number (39%) had borrowed to pay off medical expenses, either their own or others'. The majority (80%) of those who borrowed had not repaid their loans and had balances ranging from KSh 200 to KSh 5,000. Four of the borrowers had balances ranging from KSh 6,000 to KSh 23,000, indicating that the loans were relatively large. However, half of the borrowers were up-to-date with repayments. Poverty was mentioned specifically as the reason why people were behind in repaying, with all the other reasons given also associated with a poor financial situation viz. high medical expenses, no income, income not enough, and earnings not sufficient.

Box 4.7 Resource mobilisation in Mukuru kwa Njenga informal settlement

In the settlement, financial assistance comes primarily through borrowing from an individual - a friend or neighbour, often involving small amounts of money, to deal with immediate problems, typically, hunger in the home, inability to pay school fees, sickness or shocks, rent, or the need to buy clean water as that passing through the settlement is dirty and brings with it germs and diseases. Of secondary importance is participation in a merry-go-round (MGR). Examples of the latter arrangement include the following: a group comprising a few people, perhaps living on the same plot "who each pay a small monthly contribution of KSh 10 as well as bringing 1 kg rice and flour, which is given to whoever in the group is lacking. Women join together and buy utensils or other household goods. Without the group, one couldn't buy such items"; and a group of ten members, who cultivated land at home (in the rural area) to raise money. In another case, monthly contributions of KSh 200 were made, allowing larger sums of money to be lent out - for, say, capital for business, and, in this case, repayable with a small amount of interest.

As presented in Box 4.7, the FGD participants' descriptions of the sources and forms of financial assistance confirm the important role that kin and social networks play in resource mobilisation and access to credit within Mukuru kwa Njenga. This is consistent with, and reflects, the economic situation of people in informal settlements who, in most cases, do not have the collateral required by formal lending institutions, thus causing them to turn to informal institutions and exploit their social capital to access financial capital. Indeed, the concept of institutional credit appeared alien to the FGD participants and they certainly knew

of no organised, formal sources of financial assistance or lending institution in Mukuru kwa Njenga.

The findings identified above in relation to savings and credit also bring into question the validity for poor people of the concept of financial capital as defined, viz: "the financial resources available to people (including savings, credit, remittances and pensions) which provide them with different livelihood options". This definition implies some formality with regard to resource mobilisation through formal institutions for savings and for accessing credit. In Mukuru kwa Njenga and other informal settlements in Nairobi, the process of resource mobilisation is characterised by informality: money is saved primarily through merry-go-rounds. These organisations are one of the means by which people obtain financial assistance; borrowing money from a person is another. Traditionally, this has been a relative but increasingly the person is a friend within one's social network. MGRs also fulfil the function of a social organisation and as such can be considered as part of a household's social capital.

With saving and borrowing both being undertaken primarily to meet household expenses, they appear more to do with a household managing its scarce resources than with building its financial capital.

Other household income sources

Do households have any other sources of income, which could boost their financial capital? It is evident that very few household members had received any income from any other source, such as a pension or retirement fund, or some form of insurance, during the 12 months prior to the survey.

Similarly, few household members had been in receipt of any money or goods, such as a remittance, gift or inheritance, from someone who was not living in the household, during the same time period. Where this did apply, gifts were the most common form such assistance took (71%). Three quarters of the givers were related to the recipient, the most significant of whom were father/mother, and relatives of the head or spouse (other than immediate ones) (both 18%) and sisters or brothers (11%). The remaining givers were unrelated to the recipient. A greater number of donors were male (57%) than female (43%).

Over a third of the givers resided in rural areas, while another 30% of the donors were from within the informal settlement itself, and 15% lived in a formal area elsewhere in Nairobi. In two cases (7%), the giver was resident in another country. The number of times a giver helped ranged from once to 12 times in the previous 12 months, although most frequently (39%) it was on only one occasion. Although the amount of help received had not changed in 63% of cases, in 19% of cases it was reported to be less than in the past. It was not possible to clearly discern why the latter was so. The two main uses to which the help was put were food and household expenditure (46%) and rent (14%).

Another possible source of income is from rent received through renting out a dwelling. As will be amplified in the section dealing with *physical capital*, this applied to the seven households recorded as owning their own dwelling in the urban settlement: all of them rented out rooms, from which they received monthly rental earnings. In fewer than a third (30%) of cases did a household member own any other house, and these were overwhelmingly located in a rural area and almost exclusively not for rent. The findings on household assets or possessions that could be sold to raise money are also presented in the section dealing with *physical capital* below.

Other household outgoings

The study also sought to know whether households gave money or another form of assistance to anyone living outside the household. The findings show that this was the case in well over half (56%) of the sampled households. Nearly half of those to whom they gave assistance were close relatives, with parents being the main type of beneficiary (29%) and

another 20% being the siblings of the giver. Relatives of the household head or spouse, who include sisters and brothers-in-law, constituted other recipients. But many (27%) household members gave assistance to people to whom they were unrelated, which is a clear demonstration of the importance of social capital in providing financial support.

The majority (58%) of the recipients of assistance lived in the rural areas, providing one example of the existence of urban-rural ties. While this will be amplified later, it is noted here that such a tie can place enormous responsibilities and financial strain on the urban household concerned. However, a significant number (28%) of those given assistance live in the same settlement, with another 10% of the recipients living in an informal settlement elsewhere in the city. Females comprised more than half of those given help.

On average, recipients had been offered help about six times in the last 12 months. The giver in over a third of cases, they reported, had given help on much the same basis in the past as in the 12 months prior to the survey, although some had offered more help (27%) in the past and others less (21%). The main reasons for giving more help included better earnings/income, job promotion resulting in more pay, availability of money, and obtaining permanent employment. Low income, being ill in the past year, increased family commitments, financial constraints, lack of a job or loss of employment, poor business performance, and the need to begin paying high school fees were amongst the factors which contributed to less help being given.

People gave help to meet a range of needs, the main ones being: education costs (42%), funeral expenses (23%), care of the elderly (9%), and medical expenses (7%). For a quarter of recipients, the assistance came as a loan (24%); for others, it was a gift or practical help (16% in each case); while 11% received help in the form of goods, with a third (33%) given for unspecified needs. More than half of the loans were small - amounts ranging from KSh 100 to KSh 1,000. The majority of recipients did not have to repay the loan with interest.

4.6.3 Physical capital

Housing

The survey revealed that the overwhelming majority of the sampled households lived in single family dwellings, almost always in buildings occupied by several households. In almost all instances the walls and roofs were made of iron sheets and the floors of cement. In 90% of cases, the dwelling comprised one room, with 85% of households using this room for cooking as well as sleeping. Indeed, only 12 out of the 161 households had a separate kitchen used only for cooking. While 124 households indicated that they had a separate bathroom, it is important to qualify this response - generally the bathroom was shared with other households living on the same plot.

Only seven households owned their dwellings, representing 4% of the sample. Six of these had built their properties, with four of them having had a loan for this purpose, one of whom was still repaying it at KSh 1,000 per month. In all cases, the owners used their properties as a source of income, as noted above. All rented out rooms on their plots, each room being occupied by one (tenant) household. The total rent received per month ranged from KSh 700 to KSh 13,050.

Sometimes, other research has shown, owner occupiers react to hardship by renting out more rooms and reducing their own living space. The findings from this survey, however, show that there had been no change in the number of rooms occupied by the owner occupiers in Mukuru kwa Njenga over the five years prior to the survey. Most of the owners had made some investment in their houses over the previous five years, perhaps using their rental income. One owner had extended or improved his/her dwelling; two others cited insufficient regular income as the reason for not doing so. Four owners had done some maintenance and/or repairs, but two others cited the lack of money as the reason for not carrying out such work.

96% of the Mukuru kwa Njenga households are, however, tenants, most (84%) of whom pay rent. Being related to the owner was the reason most frequently given by those who did not pay rent; only in a very few cases did an employer pay.

The average monthly rent was KSh 1,000 with rents ranging from KSh 700 to KSh 3,400. For wage-earning households, this represented approximately 17% of their monthly wages. Three-quarters of the tenant respondents reported that there had been no change in the amount of rent paid over the previous 12 months, despite the high inflation rate. The previously cited World Bank study (World Bank, 2006) argues that Nairobi's slums are atypical in that the level of rents is high despite poor quality - that is, they provide low-quality high-cost shelter for low-income families. That study found that rent appeared to be second only to food among the major household expenditure items. High rental payments may also be squeezing other basic expenditures, including those on food.

Utilities

Kerosene was the main source of lighting and the main fuel for cooking for nearly 75% and 84% of households respectively. For another 18%, electricity was the main source of lighting. It is worth noting here that typically, in the informal settlements in Nairobi, households who have access to electricity can use it for lighting purposes only; the supply does not extend to wall sockets for use with electrical appliances. The average amount paid for lighting in the month prior to the survey was KSh 325 and for cooking fuel, KSh 555. Where kerosene was used for both lighting and cooking, the amount paid included fuel for both purposes.

Not surprisingly, hardly any of the sampled households had a telephone landline.

Just under 50% of the sampled households used a public tap or kiosk to access drinking water. This is slightly more than five years prior to the survey, when it was evident that a number of households were using a stream, pond or shallow well as their source of drinking water, most likely reflecting their former place of residence in a rural area.³² A public tap or kiosk was also the current source of water for non-drinking purposes for the largest percentage of households (46%), a slightly higher percentage than five years previously, possibly for the same reason as cited above. It is also evident that, generally, informal settlement residents in Nairobi use the same source of water for drinking and non-drinking purposes. The average monthly payment for water overall was KSh 427, with actual amounts paid ranging from KSh 25 up to KSh 2,240.

The landlord's pit latrine was the toilet facility used by the majority of households, with another 10% using their own pit latrine. No one had to pay for use of these or the other types of toilet facilities available in the area. Again, comparison with five years previously may not be particularly revealing in terms of a change in urban families' circumstances since it was evident that many respondents were not in residence at that time and were likely to be referring to the situation in their previous area of residence, often in a rural area. Evidence of this is suggested by the higher percentage using their own pit latrine and a lower percentage using landlord's pit latrine, and, to some extent, by one of the main reasons given for a change in type of toilet used, that is, "was living in a rural area".

As is the norm in informal settlements in Nairobi, for most households in Mukuru kwa Njenga, no formal rubbish collection system was available. Rubbish is generally just dumped in a variety of places including, in a few cases, a communal pit. It is likely that those households whose rubbish was collected were the ones who paid for its disposal.

³² The high percentage of responses coded as 'Other' under reasons for changing source of drinking water may be a reflection of this latter point.

With regard to accommodation/dwellings and each of the utilities mentioned above, the percentage of households who were dissatisfied was clearly much greater than those who were satisfied - ranging from 60% in respect of their dwelling to 76% in the case of water supply. Further investigation of what qualifies as 'being satisfied' would be appropriate, however. By way of illustration, nearly 40% stated that they were satisfied with their accommodation, their reasons including "it is all that I can afford". Similarly, nearly 40% stated satisfaction with their source of cooking fuel, a typical reason being that "it is cheap".

The overall picture obtained from the data shows that the sampled households had few possessions or household/business assets, other than the basics, which they could dispose of in times of emergency. Most owned a bed, and a sizeable proportion owned a sewing machine, with a slightly smaller proportion a radio/cassette player. A significant number (about 40%) of the respondents possessed a cellphone, while 29% had a bicycle. Smaller numbers owned a car battery (23%) and a wheelbarrow (20%) (although it is not known whether the latter was kept in the urban home or in the rural area).

Given the few possessions that people owned, the finding that the majority of the households had not sold any assets in the previous 12 months is not surprising. In the few cases where information was available, the reason for selling most frequently mentioned was to get money to buy food, with medical expenses referred to in two other cases.

One other asset that might have been available to a household was property. However, less than a third of the sampled households indicated that they owned any other houses and, almost exclusively, these were located in a rural area and were not for rent or sale.

4.6.4 Social capital

It is often asserted that social capital is weaker or is breaking down in urban areas. To assess this, attention was paid in the research to assembling information on some of the social ties of this typical sample of informal settlement residents.

Kin and fictive kin connections

Three-quarters of the adults aged 18 and over in the sampled households had spent time with between one and five relatives and/or friends from outside the household in the previous month, with three being the most common number (21%). The average number of relatives and/or friends with whom they had spent time was six. Nearly all of these friends/relatives lived elsewhere in the settlement. This may mean that, although social interaction does not generally take place very frequently, households' ties with their relatives and/or friends are strong, since the latter live in close proximity and are accessible, if required, in times of need. For over a third of the household members, the number of such contacts was reported to have remained much the same as in the previous 12 months.

As will be seen below, kin and fictive kin connections of the members of the urban household are supplemented by their external links. Of particular significance in this respect were links with their rural areas of origin (see also below sub-section 4.6.6 on urban-rural linkages).

Shaping and binding these ties and relationships are the norms and culture associated with a community or particular groups in a community, which together form, as referred to in the context of the current study, 'cultural capital'. Defined here as the norms, culture, roles and relationships, and ties which bind families/households, friends and members of ethnic groups together, cultural capital can play an important part in people's lives. Thus, whether as an asset in its own right or as a subset of social capital, it is believed that it warrants explicit consideration within the sustainable livelihoods approach.

Connections to the local community

Just over half of the sampled households had members (aged 10+) who belonged to a club, association, society, cooperative or other form of organisation. Nearly half, therefore, did

not. The most important type of organisation to which the 'joiners' belonged was a Christian church/organisation, this being mentioned in relation to 40% of the individuals concerned, with other significant types being burial societies (16%), community based organisations (nearly 10%), women's groups (nearly 10%) and savings groups (around 9%). The majority of household members had joined these organisations in the previous five years (2000-2005), with 30% having done so in 2005. By contrast, only one person reported that they had joined an organisation prior to 2000 (in 1999).

Most of the organisations concerned are located within the Mukuru kwa Njenga settlement, although it was evident that a few others are in rural areas. With regard to the mode of participation, nearly half of the joiners considered themselves to be "active" members, while a third of them regarded themselves as general members (33%). Only a few participated as leaders and/or money managers. Indeed, it was evident that participation in a leadership position (primarily as leader or money manager) was not the norm, only 23% indicating that they had ever held such a position.

A sizeable proportion (63%) of joiners had received benefits from these organisations, the most significant being money, with amounts received in the previous year ranging from KSh 100 - Ksh 100,000. Personal satisfaction and personal support/advice constituted other important forms of benefits. Had circumstances caused anyone to give up membership in the previous five years? Only a few (21%) had had to do so, with a variety of reasons being cited for this, ranging from matters concerning their own situation - economic/ financial/ employment, family, etc. - to those relating to the group/ organisation - such as poor leadership, financial mismanagement, dissolution and so forth. Over half of those concerned (57%) had given up membership in 2004 and 2005. Most had been active members.

Women's groups were the main ones from which individuals withdrew their membership, this applying in 30% of cases, with savings groups and Christian church/organisations being the next most important types. Mirroring the general picture above, those members that left their respective organisations had not held any leadership position. Over half of the organisations concerned were located within Mukuru kwa Njenga, while just under a quarter were situated in rural areas.

For the majority, withdrawing from the membership of these organisations meant foregoing benefits, particularly money, but also the personal support/advice and satisfaction gained from membership.

Surprisingly, in less than a quarter of cases had household members aged 14+ participated in any other form of collective activity in the previous year. Social events and maintaining roads/ drainage were the two most significant activities in which people had participated (52% and 38% of participants respectively). Well over half participated by contributing their labour or, in a few cases, materials/money, while many others (29%) did so by attending meetings.

What could explain the finding that, in the case of three-quarters of the sampled households, none of their members had participated in any collective/community activity? Was it due to lack of time? To a hard-pressed community? To individualism? Or are such people not part of the mainstream of community life and so not involved in community affairs and the local decision-making process? Even for those who had participated, the majority had only been involved once or twice in the previous year, devoting altogether between one and four days.

There was not a clear-cut picture as to whether people's participation had increased or decreased in the period 2000-2004 nor of the reasons for any change. In respect of the latter, there was a large proportion (nearly 60%) of unspecified reasons. The main specified reason for reduced participation was lack of money to contribute. It was evident that the majority (62%) of those who participated received some benefits, including improved services/infrastructure, personal satisfaction and money. However, a significant minority of

those participating (36%) did not get any benefits, perhaps explaining why the level of participation in collective activity by the sampled households was low.

It is concluded that, overall, linkages *within* the Mukuru kwa Njenga community through membership of organisations and participation in community activities are limited. However, households' connections to their local community also depend upon the extent to which community based organisations (CBOs) and other civil society organisations are active in the settlement and people's awareness of them.³³ The findings of the FGDs amplify the latter point.

Generally, the FGD participants seemed largely unfamiliar with CBOs or local non-governmental organisations (NGOs) operating in the settlement and what their role was: "they are there but I do not know about them" was a common view expressed. The community groups they had heard about included the following: people living in the same plot get together and hold meetings; if someone has a business, then people associated with it join to form a group or, similarly, there is a group formed of several *jua kali* workers; there are burial groups but these are based in the rural areas. Ethnic groups also exist - for instance, "in the community, there may be one or two people of your tribe, who get together" - but such groups are also more rural-oriented. Merry-go-rounds (MGRs) were also mentioned, but it was claimed that they were not common in the area.

Given the above, it is not surprising to find that only two participants indicated that they were members of a community-based organisation (although a number of women had stated previously that they belonged to a MGR). Not belonging to a group or not participating in community activities may also indicate that people do not wish to socialise, preferring to keep themselves to themselves for one reason or another, which was the view of some of the FGD informants. Thus, "some people living in the same plot do not like socialising and it is just because of problems that they are there otherwise they would build and live on their own" or "Others do not want people to know them since they think you cannot help them in any way". In other cases, it was considered that "Some do not want their background to be known. Others hide because they are criminals" while it is not possible to get to know those who work long hours as "they leave early and come late".

Turning now to *external* links, the household survey sought to explore what connections the community had to government and non-governmental organisations. For instance, had anyone in the sampled households ever held a recognised government, political or administrative position other than regular employment? It is evident that, in almost all cases (98%), none had held such a position. What other formal forms of contact were available whereby people interact with government agencies and have access to information about community affairs?

The FGDs revealed that the settlement as a whole had community leaders, but these were seen as government appointees, the participants indicating that they did not know what their role was. There was also scant knowledge about village leaders in Mukuru kwa Njenga - whether they existed or not. Although, as mentioned previously, zonal committees, each comprising a village elder and a woman and a youth representative, had been set up in each of the settlement's seven zones, the participants knew little about them. Under these circumstances, how do members of the community get informed about events, such as free medical camps in their area? A few channels of communication are available - for instance, people go to the Chief's Office or "leaders call us and tell us...what is happening and what we should do"; while the churches announce events during their services.

In respect of the community's connections with NGOs, a similar picture to that above emerges: the majority (84%) of household members had held no position of responsibility.

³³ A list of CSOs and other stakeholders is provided in Annex 2, which is based on information collected from the chairmen of the zonal committees and from other sources.

For the few who had done so (16%), the positions were mainly in Christian churches or Christian church organisations (54%). The other main types of organisations included women's groups, ethnic associations and CBOs.

Such positions were generally held at the time of the survey (44%), with another 22% having been held in the previous year. The positions were held for a short duration - less than six months - in over a quarter of cases, and for between 6-12 months in the case of nearly another 20%. Over a third (37%) had held their position for between one and three years. Of the 27 people who held positions of responsibility, the majority had been elected, with another substantial number having been appointed. The main responsibilities of the position were, in descending order of significance, leader, money manager and activity manager.

Identifying what NGOs are operating in a settlement, what activities they are supporting, what capacity building activities are being undertaken, what groups in the community are being targeted, and so forth is an additional way by which to assess a community's linkages with the wider society. Suffice to note here is that, although a number of NGOs were identified as active stakeholders, it was evident from the survey, as well as from the FGDs and general observation, that people either did not know of them or, if they did, felt excluded from them or were not part of the organisation's target group. Indeed, it was evident from the FGDs that there was even less awareness about the presence of the NGOs in the settlement than about CBOs, suggesting that they play a very limited role in the lives of most Mukuru kwa Njenga residents. It was felt that the NGOs that were operating were "personal" and that people who did know of them and were involved in their activities "keep it to themselves until the project is over". The participants explained that the person who would know about NGOs would be the Chief, since such organisations have to get approval to operate in the area from the Provincial Administration.

With regard to other external links, a majority (70%) of adult household members had made visits during the last year outside the community, which required them to stay away for more than one night. During this period, most (35%) had made one journey and 27% had made two, although the overall average was 4.3.

With regard to their most important journey during the previous year, the majority indicated that this had been to a rural area. Primarily, people had visited their relatives, both relatives of the head of the household (49%) and the spouse (15%). In addition, some (15%) had visited their farms.

The reasons for the journey were many and varied but the main one was social - primarily, a social visit to a relative (48%) or, in a few cases, to a friend. A significant percentage (14%) visited for funerals and also agricultural activity (12%). Many of those who made the journey stayed away for between one and seven days. Some stayed for a month.

Compared with five years previously, nearly 40% felt that they had made the same number of journeys, with roughly equal proportions (just over 20%) considering they had made more or fewer. Amongst the multiplicity of reasons given as to why there were fewer visits, "busier now", "financial constraints", and "got married" were the most commonly mentioned. It was not possible to ascertain clearly specific reasons for more visits being made than previously.

It is evident that visits to destinations outside the immediate community, even though they may be costly and an added strain on households' limited financial resources, are common amongst the sampled households, with rural destinations appearing to be the most important, both for social and agricultural purposes. This undoubtedly keeps people in touch with what is going on with the immediate extended family, but what of events happening elsewhere in Nairobi or in the country as a whole?

The sampled households make substantial use of a range of communication channels. All of the respondents indicated that they or other household members listen to the radio; a large

number also watch TV. A substantial number (78%) read a newspaper, with a significant number (57%) writing letters. A surprisingly large number, constituting 88%, talk on the telephone (it was not ascertained whether this was by public telephone or mobile - as previously indicated, mobile phone ownership in the settlement was about 40%), while others reported that they ask someone who had travelled outside the city (81%) or relatives/ neighbour/friends (88%); or that they attend a local event/rally (65%).

In conclusion, the overall impression gained is that there is a weak social capital asset base in Mukuru kwa Njenga - at least in terms of the social networks formed through community participation, regular contact with village and community leaders, accessing and sharing of information and so forth. This does not, however, mean that residents have few social ties or are isolated from the wider world.

4.6.5 Natural capital

In respect of natural capital assets, the household survey focused particularly on land and the use of it for livestock and agricultural production, with a view to analysing its importance as an asset yielding flows of income or goods as well as its potential for realisation in times of need.

Land ownership

The survey sought first to establish land ownership, its location and method of acquisition. Only 17% of the sampled households had a garden next to their urban dwelling, which could be used for urban agriculture. However, many (40%) of them had use of a *shamba*³⁴ or land "elsewhere", mainly in a rural area and thus possibly available for agriculture or livestock production. Of those who had use of land elsewhere, it would appear that 72% of the households actually owned it. Only a few households owned more than one *shamba* or "plot".

Of those who owned land, just over half did so on a collective basis, indicating family land. Of those who owned land, 43% had acquired it through inheritance and 37% through family allocation, with most of the rest having bought the land with cash or a loan, or having accessed it by "self-allocation" or just occupying the land. Many of those who had inherited land did so from their father. A very few households had inherited land from the natural mother of a household member. Generally, most households had use-rights, which had been acquired through family allocation. Strictly, when the term "ownership" is used, it actually refers to use-rights, as the individual household member's plot continues to belong to the extended family and is not allowed to be sold in times of need. In other words, there are restrictions over the realisation of this asset.

Information from the FGDs provides further amplification of this latter point. The discussions sought to ascertain how realisable land, as an element of natural capital, was as an asset to an urban household in, say, the event of a shock affecting that household. There was consensus amongst the participants that, although a person may have been allocated or inherited a plot of ancestral land, this does not signify ownership, as captured by the following comments: "It's yours but not owned"; "It is yours but you were just allocated it."; "It's yours to cultivate only"; and, "It's yours traditionally since you are given it". Ownership would only arise if one had obtained a title deed. As family land, it comes with certain conditions and, in the event of a problem or shock, one "can't just do anything with it such as selling it" to buy food or clothes, for instance. According to one participant, "If a child is to join University, that's the only case where land can be sold after discussing it with one's parents".³⁵

³⁴ A *shamba* is land used for farming, whether for agriculture or livestock production, or both.

³⁵ This comment again highlights the significance attached to education by the Mukuru kwa Njenga households.

Secondly, there seemed to be agreement that the collective land is associated with usufruct or use rights, rather than ownership rights, which prevents it from being a realisable asset when a household is faced with problems. Nevertheless, it does provide some benefits, such as food from the produce cultivated on the plot, a place to build a rural dwelling (the structure of which is personally owned), and status - "you can boast that you have your own piece of land". It was pointed out, however, that there are some constraints on cultivating the land because of lack of time and the expense of travelling to the rural area, or the cost of paying someone at home to work on the land. Perhaps because of these constraints, there appeared to be limited use of the plots for food production, lending credence to the one of the household survey findings as discussed below.

Land usage

The survey found that the land owned by 61% of the households had been cultivated in the previous year, with the father and the mother within the extended family being those who did most of the cultivation work. Where the plots had not been cultivated in the previous 12 months by members of the household, then in about three-quarters of the cases someone else had taken on this task. Relatives were again used but so also were hired farm hands.

Maize was the crop most commonly grown - in over 80% of cases, followed by beans (66%), other vegetables (35%) and bananas (30%). Other crops grown were millet, sorghum, and cassava. About a quarter reported that they had grown cash crops on the plot. With regard to the main types of livestock kept on the land, goats were the most common (60%), followed by poultry (just over 50%) and cattle (50%).

Amongst those households who owned or had use of land, the survey sought to establish whether they earned any income from the farm produce. It was evident that only a third of households had sold any produce in the previous 12 months, average earnings from this being KSh 13,166, with the amount ranging from KSh 240 to KSh 60,000. Only six households (fewer than 10%) reported that they had processed crops for sale, earning between KSh 2,000 and KSh 30,000. Under half the households concerned had eaten the crops produced on their rural land, with even fewer (13%) consuming crops produced by members of the household on urban land.

Few households had either started any new agricultural activity in the 12 months prior to the survey or stopped doing any. The main reasons for stopping were that their land was not close by but in a rural area and the time involved in reaching it. Other reasons were that the plot was too small, lack of funds to invest, and no market for the produce. For the few who had stopped, there was no indication that this was due to ill-health.

Livestock/small animal ownership

Less than half (43%) of the households owned or shared livestock or small animals and in relatively small numbers, as the following figures show. 45 households reported owning cattle, 19 of which were shared, while 27 owned goats, five of which were shared. 23 households had donkeys, six of which were shared, and 15 owned poultry, with three households sharing. The number of livestock and poultry owned ranged from one to 40 but, on average, households owned between six and 10 animals and/or poultry. A few others owned other types of livestock as well: six reported owning oxen, seven owned sheep, and three owned pigs.

In the past year, a fifth of households (about 20%) had sold either livestock or poultry but only in small numbers. The number of livestock sold ranged from between one and eight of each type of animal but, on average, a household sold only one of each type. The three **main** reasons for selling livestock were to deal with a financial problem, to pay school fees and to meet household expenses. The number of poultry sold ranged from two to 18 but, on average, households sold three. Again, people sold poultry to pay debts, to pay school fees, and/or to meet household expenses. Few households appeared to have used their livestock or poultry for their own consumption in the previous year.

In the past year, any increase in the stock held by a household was mainly through birth; receiving additional stock by gift was not common. Only a few households experienced a decrease in their stock through theft, giving an animal/animals away or loss. The data seems to suggest that, on average, most households had experienced a net gain in their stock over the previous 12 months, with poultry making the greatest contribution.

Of those owning livestock, had any households produced any livestock products in the previous year? The survey found that eggs were produced by 68%, milk by 63% and meat by 53%. Only one household had produced honey. Most households produced these products in the rural and not in the urban area. It follows, therefore, that more households consumed their own produce from a rural area than those producing produce in the urban area.

Apart from home consumption, some produce had also been sold in the previous year. Milk was the main product sold, by nearly a third of the households concerned, which earned them between KSh 600 and KSh 20,000 (on average, KSh 7,000). Only three households had earnings from egg sales: KSh 5,000, KSh 6,000 and KSh 10,000 respectively. Only one household appeared to have earned any money from the sale of meat (KSh 4,000).

It can be argued on the basis of this evidence that land as an element of natural capital and its potential to be used as an asset in times of need is of greater significance to an urban household the stronger the latter's links are with its rural area of origin. As seen, the household survey provided some discrete pieces of information about urban-rural linkages amongst the sampled households, but a comprehensive picture of the status and significance of the relationships, which would have enabled an assessment to be made of their function in relation to households' livelihood strategies, did not emerge. The FGDs provided another means of exploring the linkages, with some useful insights being gained, as presented below.

4.6.6 Urban-rural linkages

One FGD sought to obtain more information on the significance of urban-rural linkages in the context of the livelihood strategies adopted by urban households. Is, for instance, the link supportive in times of need and thus can it be used as an asset, or does it have a negative impact, putting a strain on other household assets? Can the link be mutually supportive? First, though, with families in Nairobi's informal settlements now extending through three or four generations, it was important to ascertain whether linkages with their rural areas of origin have been maintained.

The discussion gave a clear indication that the link between urban households and members of their extended families living in the rural home is being maintained, as succinctly portrayed in the following remarks: "It's normal. On holiday, children go to visit grandparents and familiarise themselves with the environment"; and, "It's good to take them to know grandparents and great grandparents". Other comments illustrated the feeling of obligation with regard to maintaining contact. Thus, "It is we who come here and we go to visit and take help so that they don't feel as if we've forgotten them"; and, "Now that we are here, there are some people back at home and parents need help". Another sentiment echoed was that the rural home remains the "real" home: "You know home is the best. East or west, home is the best. It is a must to go home". How often someone was able to go to the rural area and visit relatives depended upon the distance from Nairobi and whether one had enough money for the bus fare.

The FGD participants also provided insights into the benefits to be gained from linkages between them and their extended rural families, as captured in Box 4.8.

The findings provide clear evidence of the maintenance of urban-rural linkages - and thus, of their continuing significance. Yet there was general consensus amongst the participants that these links are becoming weaker, as the following remarks illustrate: "We used to meet at the end of the year in the village but nowadays everyone is independent and people laugh at you if you are declining financially"; "It [the relationship] is not growing since before there was money and jobs"; and, "If there is livestock at home and somebody has been left to take care of it, without good pay they cannot do it". Indeed, money appears to be the primary cause of weakening relationships: "If you don't assist parents, they claim you are lost in town but it is lack of money". Financial problems facing urban households have led to them catering for their own needs first.

Box 4.8 Urban-rural linkages: mutual benefits?

The FGD participants considered that, overall, rural families benefit most from relationships with their urban kin, at least financially: "The relationship benefits rural folks. They depend on us for finances. They benefit more than us. They benefit since we remit what we earn back home". Indeed, there is almost an assumption that those who live and work in the city do so in order to send remittances to the rural home: "We come to Nairobi to earn and remit back home, not from home to town. We leave the money there"; and, "If you go empty handed, they look and say you went to earn and bring something home". It is recognised that "Life there is a struggle".

However, the benefits ensuing from the relationship are not one-sided by any means; often it is of mutual benefit. The kind of support received from the rural homes often involved looking after urban residents' *shambas* and/or their property, and caring for their children. "They assist us cultivate our land. Sometimes one is unable to go... thus rural folks help in the *shamba*". Another view was that the **only** way the rural families can help is "when there is a *shamba* and they receive the money you send, which they can use to do farming. The produce can then help them and the children". Also, "When you buy property and leave the rural area, they take care of it - thus you continue supporting them since they've taken good care of your property."

The latter also applies with regard to looking after children. "There is support since they take care of children and you remit money back home since you can't [afford to] come with the whole family here. Thus you support them as they support you, too". Similarly, the support received by urban residents was seen as coming through having somewhere to send their children - it was felt that many people in the community have children living in the rural areas since, without work in Nairobi, they have no income to look after them. Even for those with work, leaving children with their grandparents was considered preferable: "My daughter has a child and I prefer her to be with my grandparents since I go to do *jua kali* work together with my daughter and I have nowhere to leave the child". Also, on the death of a Mukuru kwa Njenga resident from HIV/AIDS, his/her child/children are "usually taken to their relatives back at home in the rural areas" to be cared for.

Certainly, the support one can obtain from home is not financial - one cannot go home "to get money" but "home support can be given if you've tried all other ways and you're unable to get anything" or "If you go to your mother without anything she still gives you food, which is cheaper than buying in urban areas". It can be even less tangible: "one's parent asks you to visit even without anything. We go for blessings".

In conclusion, although the benefits which the participants saw ensuing from their connections with their places of origin tended to favour those people located in the rural area, the weakening of these linkages could also reduce the range of livelihood strategies available to urban households living in Mukuru kwa Njenga.

5.0 Conclusions and policy implications

This section draws together and summarises the main conclusions which have emerged from the preceding discussion, and then considers the policy implications thereof. Conclusions on the economic, health, social and physical environment of the residents of Mukuru kwa Njenga are first presented.

5.1 Poverty, economic hardship and ill-health

The livelihood strategies adopted by households are a reflection of their particular circumstances. The analysis of households living in the Mukuru kwa Njenga informal settlement suggests that most are faced with continuing poverty and entrenched economic hardship, they suffer from intermittent sickness or short-term illness rather than long-term health problems or major disabilities, and they deal with ongoing stresses occasioned by sporadic shocks. The infrastructure and services remain woefully inadequate.

There were also indications that people's circumstances were deteriorating. The findings of a survey undertaken in 2005 showed that there had been an increase in the percentage of the national population living below the poverty line. From the perceptions of the sampled households, it appears that this was reflected at the settlement level.

Thus, taking one criterion of poverty - income, the majority of respondents (70%) regarded their household income as not adequate, with another 30% considering it just adequate. Furthermore, with regard to the assessment of another indicator of poverty, the adequacy of food consumption (of staple foods) in the 12 months prior to the survey was recorded as not adequate for 41% of households.

As recognised by the household livelihoods framework and other research, poverty is not a stable, permanent or static condition. Poor individuals and households move in and out of poverty, depending on the opportunities at their disposal and the stresses to which they are exposed. This study attempted to assemble evidence on the trajectories of the households studied by asking questions about the one and five year periods prior to the survey in 2005, but the limitations of retrospective questions in a one-off survey meant that it was unable to fully track changes in their income and well-being.

Nevertheless, comparing current income with that five years prior to the survey (2000), 37% of households considered themselves to be a little or much worse off, compared to 25% of the households who thought that they were in the same situation and 27% a little or much better off at the time of the survey. This apparent deterioration in the circumstances of four in ten households was reflected in an overall average decrease in consumption of staple food and vegetable protein and in a decrease in the average number of days a week that all the different food items (vegetables, fruit, vegetable protein, meat and other animal protein, and tea/coffee) were consumed, compared with five years previously.

5.2 Deployment of capital assets in livelihood strategies

Households' livelihood strategies are dependent upon their initial asset endowment and their capacity to manage, access and transform their assets. The analysis of household characteristics by the five livelihood assets has enabled some conclusions to be drawn about asset endowment amongst the sampled population in Mukuru kwa Njenga. Wherever possible, an assessment has also been made of households' capacity to manage and access their assets. The following concludes on how the latter are transformed or drawn upon by households in the formation of their livelihood strategies. In this respect, it is important to note the inter-dependency between the assets, which may affect how they are deployed, as well as being a factor in determining the shape of a particular strategy.

Taking *human capital* first, this can be described as being multi-dimensional, since it embraces household composition, labour resources, levels of education and skills, the health status of household members, and so forth, all of which have a bearing on the shape of a particular livelihood strategy. Household composition may also be of particular significance with regard to how a household manages, accesses and transforms its assets. As noted previously, in the Mukuru kwa Njenga sample population, there were more males than females and male-headed households predominated.

With regard to household relationships, it has been surmised that the relatively high degree of stability and permanence characterising the relationships within the households may provide household members with an internal support mechanism on which they can rely when required. It is also suggested that, with the presence of the spouse of the household head in the household on a sustained basis, a number of social, economic and health benefits may be forthcoming, which can contribute to a household's overall well-being and self-reliance, and bolster its ability to deal with hardship.

Ethnic ties may also be an important support mechanism for household members of the same ethnic group. This may be particularly significant with respect to the dominant group in the settlement, the Kamba, to whom a large majority of the household heads belong. Such a support mechanism is likely to be reinforced by strong kin and fictive kin connections, which were found to be of significance in the area.

A population which is relatively mobile, as the findings on migration indicate, may, however, find it difficult to develop relationships between households and between household members and the wider population in a settlement - in other words, the formation of social capital. Indeed, as previously noted, the overall impression gained is that, in terms of more organised social groupings, there is a weak social capital asset base in Mukuru kwa Njenga, limiting the extent to which this form of capital can be drawn upon by households in pursuit of their livelihoods.

Turning to health status, it has been argued that, if people's labour resources are weakened through intermittent sickness or short-term illness, this can impact negatively on their livelihoods. Reduced productivity can affect income-earning potential and can, ultimately, lead to termination of employment. Functioning below par can also constrain those who are actively seeking work. In turn, people's ability to build up their financial capital base may be weakened. Intermittent and short-term illness, especially malaria, was found to be common amongst the people of Mukuru kwa Njenga, not least because of the appalling environmental conditions in which they live.

The study intended to evaluate the impact of HIV/AIDS, in particular, on the wellbeing of low income households more generally. In practice, this was even more difficult than anticipated and no clear conclusions can be drawn. However, evidence from the study does show that men have fewer opportunities than women to learn their HIV/AIDS status - for instance, women's awareness is enhanced through the prevention of mother-to-child transmission initiatives - and are less willing to find out their status through attending a VCT and being tested for HIV/AIDS.

A specific finding of the study concerned the way in which those who were wage earners reduced their vulnerability in the face of illness: they rarely took any time off work, because taking time off would mean putting their jobs in jeopardy.

Two other forms of coping strategies vis-à-vis health were noted. First, concerning delivery arrangements: in response both to economic hardship and lack of access to government services, a high percentage of women gave birth at home with the assistance of a TBA or a relative/friend. Secondly, as seen from the FGDs and the life histories, when a household

suffers the death of a parent through HIV/AIDS, then it is common practice for the orphan child/children to be sent to live with the extended family at the rural home.

While relatively high levels of education and skills characterise the informal settlement population, poor job opportunities in the formal, waged sector, in terms of the number and type of positions available, limit the chances of people to realise the potential of their labour resources. Faced with this situation, it is evident that people turn to the informal sector as their source of employment. However, for many households, pursuing this livelihood strategy appears to be constrained by their lack of **financial capital** and limited access to formal credit institutions. Although people in the settlement sought, alternatively, to obtain financial resources via their social capital, as has already been noted, Mukuru kwa Njenga does not appear to be well-endowed with the latter.

Enhancing one's financial capital base through savings was not generally an option available to these predominantly poor households. Even for those who do save, the term 'savings' has a particular connotation, at least in respect of the main form of institution used for this purpose, the merry-go-round (MGR). When it is the turn of a MGR member to receive his/her savings, the money is generally spent on outstanding and pressing household items - food, rent and medical expenses.

In the face of economic hardship, households prioritise with regard to what they can purchase: expenditure on items other than food, such as toiletries and services, was found to be either very low or almost non-existent. For the majority of households, no expenditure was made on entertainment either. On the other hand, a surprisingly high percentage of households financed their medical treatment from household earnings although this could mean having to cut back on other basic expenditures such as food.

Turning to **physical capital**, most households were poorly endowed with possessions or household/business assets, other than the basics. Selling assets in times of need to raise some money was, therefore, clearly not a livelihood option available to them; neither was using their house/property as collateral, as almost all householders were tenants and not owners.

It is commonly argued that, in poor urban communities, where traditional support mechanisms provided by the extended family may not be available, where formal public safety nets may be non-existent, and when personal assets have been exploited to their fullest, it is to informal social networks and support arrangements - **social capital** - that people turn. According to the findings of a recent assessment of support mechanisms in informal settlements in Nairobi (Amuyunzu-Nyamongo and Ezeh, 2005), bereavement was the most significant problem which received community support, followed by serious illness requiring hospitalisation. Lack of food and minor illnesses were seen to be commonplace and, therefore, not deserving of community-wide intervention.

In Mukuru kwa Njenga, there is a weak social capital asset base - at least in terms of the social networks formed through community participation, whether via membership of a community-based organisation or involvement in community activities, regular contact with village and community leaders, accessing and sharing of information and so forth. Accordingly, under these circumstances, households are likely to be constrained in the extent to which they can tap this form of capital asset for material and emotional support in areas such as those noted above.

Moreover, the ability of the community, of which households are a part, to "have a voice" and to engage with governmental and non-governmental organisations providing resources or initiatives at the settlement level aimed at reducing poverty and/or enhancing livelihoods, is also constrained. By way of illustration, an approach adopted by the National AIDS Control Council is to mobilise CBOs and faith-based organisations to develop proposals for accessing funds to address the problem of HIV/AIDS. Clearly, the situation which appears to

prevail in the Mukuru kwa Njenga informal settlement hinders the community's ability to take advantage of such an initiative.

One possible explanation for the under-developed social networks and community support arrangements is revealed by the study - that residents work long hours and leave early for work or to look for work and return home late, leaving them with little time for engagement in social or community activities. However, it was also evident that, although CBOs and local NGOs are present in the area, residents are either unaware of their existence - and hence of the benefits which membership could bring, or considered that they served only particular target groups in the community - that is, that they were not inclusive.

On the other hand, households' ties with their immediate relatives and/or friends appeared to be strong, possibly further strengthened when such connections are within the same ethnic group. Indeed, the norms and culture which help to define the roles and relationships amongst the members of a particular group or community together constitute another form of capital, **cultural capital**, a resource that can be used by those concerned when in need.

It was evident that ties are also maintained with members of the extended family living in the rural areas - visits were found to be common - so this form of capital may be seen to extend beyond its urban context. Accordingly, it is closely linked with the discussion concerning **urban-rural linkages**. The assessment of the latter concluded that, while they are becoming weaker, linkages are still an asset for many urban households, and bestow some benefits on them, albeit of a somewhat intangible nature in some instances. In cases where such linkages are being eroded, there will be a corresponding reduction in the range of livelihood strategies available to the urban households concerned.

An urban household's links with its rural area of origin may also be of significance when it needs to realise the potential of any plots of land, an element of **natural capital**, which it may hold in the rural area. However, since it is common for households' plots to constitute family land that is associated with usufruct or use rights, rather than ownership rights, the extent to which land is a realisable asset when a household is faced with problems is restricted. Other constraints, including lack of time and the expense of travelling to the rural plot, also appeared to reduce the household's ability to transform this asset - for example, for growing food crops for consumption and/or sale.

5.3 Policy implications

The following briefly looks at the policy implications of the foregoing conclusions, with a view to providing pointers for policy makers on areas which need to be addressed if poor urban households' asset base is to be strengthened and their capacity to manage, access and transform their assets enhanced. Again, inter-dependency between the assets will have a bearing on policy-making.

- **Enhanced gender mainstreaming in HIV/AIDS programmes**

A gender mainstreaming approach to HIV/AIDS is already government policy, being embodied in the current Kenya National HIV/AIDS Strategic Plan. However, in view of the findings above, it is suggested that its application be enhanced to ensure that males are targeted more effectively.

- **Support to the informal sector**

With their relatively high levels of education and skills, there is potential for people in Mukuru kwa Njenga to draw upon their labour resources to improve their earnings - provided that, amongst other things, job opportunities are available. It is evident that households have recognised that it is the informal or *jua kali* sector where such opportunities will have to be sought. Existing government policy, too, recognises that, in the foreseeable future, it is the

informal sector which will play the major role in job creation. At the same time, the informal sector, which correlates closely with the informal settlements, contributes significantly to the local economy. Yet, there is no specific policy at the local level which addresses the economic potential of informal settlements or of *jua kali* businesses. As the recent Nairobi urban sector profile notes, "If slums are to achieve their economic potential, their role in the city economy must be well understood and the relevant communities' needs and opportunities identified" (UN-HABITAT, 2006).

In the present context, consideration will need to be given to the provision of an enabling environment within the informal settlements for the *jua kali* sector to prosper. Amongst other things, the following will require attention: reduction of existing constraints such as the inadequate infrastructure in terms of both provision and access; the promotion of micro-finance institutions which provide credit facilities accessible and affordable to poor people; the designation of suitable sites within settlements for small-scale businesses, and the application of appropriate and pro-poor standards, requirements, licensing fees, and so forth, for their operation. Building and enhancing people's skills and knowledge to facilitate them to establish and run small-scale enterprises would also be appropriate.

This area of potential policy focus is closely linked with the following.

- ***Support to informal settlement upgrading***

The lack of facilities and services within Mukuru kwa Njenga severely limits the livelihoods of people in many respects including, as noted above, their economic well-being, so clearly progress towards provision is essential. There was in 2005 an active interest in this area by government and development agencies, an opportunity which can be exploited. But experience shows that a coordinated, collaborative and partnership approach to slum upgrading through all its stages is vital - from planning to ensure, for instance, that appropriate standards are adopted as allowed through the use of the Special Planning Area status under the Physical Planning Act, 1996; to resource mobilisation to effectively tap existing and potential sources of funding such as the Local Authority Service Delivery Action Plan, the Constituencies Development Fund, National AIDS Control Council, development agencies' programmes and NGO initiatives; and to implementation and operation and maintenance - to encourage innovative and sustainable approaches such as community contracting and community asset management to be employed.

- ***Promotion of social capital***

A way forward with regard to enhancing households' access to social capital within Mukuru kwa Njenga would be for both government and non-governmental organisations to encourage the mobilisation of the community, the formation of groups, and the use of community participatory approaches. There are a number of NGOs in Nairobi with a proven track record in these areas, which could be used in this regard.

- ***Promotion of a coordinated and collaborative approach to urban poverty in Nairobi***

The weak and uncoordinated policy and institutional response to the needs of poor urban households in Nairobi continues to be a matter of concern which requires attention. Policies, programmes and activities are implemented by a range of institutions within the public, private and civil society sectors in the absence of any proper dialogue or coordination. Coupled with this is the lack of a local development planning process which would provide a framework for the identification of programme and project proposals, resource allocation and resource mobilisation, to which the stakeholders at different levels and with different areas of focus can subscribe and work together on a partnership and collaborative basis. A forum or mechanism which would facilitate the latter is worthy of consideration.

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Annex 1 List of main organisations and persons met

Organisation	Person/position
African Population & Health Research Center	Frederick Mugisha
Cana Family Life	Mary Mambo, Executive Director
Central Bureau of Statistics	Peter Nyongesa
Department for International Development, Kenya	Marilyn McDonagh, Health Adviser
Kayole Jua Kali Association	Joshua Kasera, Chairman
Kensa Youth Concern Initiative	Charles Mukabi
Kenya AIDS NGOs Consortium (KANCO)	Allan Ragi, Director
KANCO	Joyce W. Muthee, Resource Centre Assistant
KANCO	Miano Munene, Programme Manager
Mukuru kwa Njenga Zonal Committees	Committee Leaders and Members
Nairobi City Council	Mr. P.M.G. Kamau, Assistant Town Clerk (Admin.)
Nairobi City Council	Mrs. Mishi Mwatsahu, Director of Social Services & Housing
Nairobi City Council	Engineer Christine Oguti, City Engineer's Department
Nairobi City Council, Nairobi Urban Slums Project	Ruth Nguge
National AIDS Control Council, District Technical Committee (Nairobi)	Michael Oyalo
Provincial Administration	DO, Embakasi Division
	Chief, Mukuru Location
	Assistant Chief, Mukuru kwa Njenga Sub-Location
UN-HABITAT	Joyce Mbugua, HIV/AIDS Consultant, Urban Management Programme

Annex 2 Stakeholder identification, Mukuru kwa Njenga informal settlement, August 2005

Type of Organisation/ Name of Organisation	Details
Community-Based Organisation/	Mukuru kwa Njenga Sub-Location Level
1. Vietnam Zone	
Home-based Care	<ul style="list-style-type: none"> ▪ Membership: 16-20 members (mixed men/women) ▪ Registered ▪ Activities: environmental cleaning, food security, home-based care for HIV/AIDS victims ▪ Funding: well-wishers and friends (but shortage of funds) plus support: from Catholic nuns - food, home-based care to sick, orphans, etc.
Maridadi Women Group	<ul style="list-style-type: none"> ▪ Membership: 40 members (women only) ▪ Registered: 2001; operating for 4 years ▪ Activities: merry-go-round to support the sick; beauty/traditional culture (utamaduni) - beadwork, necklaces, earrings, floor mats, table mats; support to widows (12) through tie-dye clothing ▪ Funding: applied for loans but not yet obtained
2. Riaru Zone	<ul style="list-style-type: none"> ▪ No CBO activity currently as new zone still developing
3. MCC Zone	
Zion Women Group	<ul style="list-style-type: none"> ▪ Membership: 89 members (84 women/5 men) ▪ Registered: 2001; in operation since 1999 ▪ Activities: selling charcoal; previously chicken selling but this activity collapsed
4. AA Zone	
Mukuru Water Project (Self-help Group)	<ul style="list-style-type: none"> ▪ Membership: 26 members (men/women) ▪ Registered: 2005; started in 2004 ▪ Activities: provision of water services on commercial basis ▪ Funding: members' contributions; councillor's support
MKEN (Self-help Group)	<ul style="list-style-type: none"> ▪ Membership: 20 members ▪ Registered: January, 2004; in operation for 1 year ▪ Activities: environmental cleaning; garbage collection; sewerage unblocking and sewage disposal, and drainage systems ▪ Funding: friends' and well-wishers' contributions
Motomoto Women Group (Housing cooperative society)	<ul style="list-style-type: none"> ▪ Membership: 35 women ▪ Registered: 2001; in operation for 4 years; now a housing cooperative society; very active and stable group ▪ Activities: dancing, singing and entertainment: buying land at Kitengela (Athi River) ▪ Funding: from politicians; loan from banks for buying land and for house construction
5. Wapewape Zone	
Angaza Youth Group	<ul style="list-style-type: none"> ▪ Membership: 20 members (mixed boys/girls) ▪ Registered: 2003; in operation for 2 years; active group ▪ Activities: early child development programme (nursery school); HIV/AIDS awareness; environmental cleaning and sanitation ▪ Funding: networking with UNICEF; no funding from any donor; fees from nursery school are utilised for sustainability
Vumilia Self-help Group	<ul style="list-style-type: none"> ▪ Membership: 35 members ▪ Registered: 2004; in operation for 1 year; breakaway group from Highlands Community Assistance Programme (HCAP) ▪ Activities: ▪ Funding: assisted by Cana Family Life NGO on training on HIV/AIDS and counselling, and feeding programme for sick children/orphans

Type of Organisation/ Name of Organisation	Details
Community-Based Organisation/	
5. Wapewape Zone cont.	
GoGo Women Group	<ul style="list-style-type: none"> ▪ Membership: 28 members (mixed men/women) ▪ Registered: 2001; in operation for 4 years; not an active group ▪ Activities: merry-go-round; helping the sick by giving contributions ▪ Funding: own contributions
Quarry Garbage Collectors	<ul style="list-style-type: none"> ▪ Membership: 30 members ▪ Registered: 2001; in operation for 4 years; active group ▪ Activities: environmental cleaning and garbage collection; HIV/AIDS ▪ Funding: members' contributions
6. Milimani Zone	
Kazi na Njasho	<ul style="list-style-type: none"> ▪ Membership: 40 members (men/women/youth) ▪ Registered; in operation for 2 years ▪ Activities: environmental cleaning, sanitation, running seminars (environment, rights, HIV/AIDS) ▪ Funding: World Vision (provision of wheelbarrows, shovels)
Alice Health Services	<ul style="list-style-type: none"> ▪ Membership: 20-25 active members (women/men) ▪ Registered, and in operation since December, 1996 ▪ Activities: health diseases services, VCT centre, maternity services, family planning; assists the injured for free ▪ Funding: World Bank sponsors VCT services; cash donations from well-wishers to run operations
Serenity Collection	<ul style="list-style-type: none"> ▪ Membership: 25 active members (women/men) ▪ Registration: applied for; operating for 1 year ▪ Activities: community health and home-based care; small income-generating activities ▪ Funding: contributions from members; St. Mary's Dispensary (Catholic sisters at St. Elizabeth Catholic Church, kwa Njenga) assisted in training on home-based care
Monsoon Youth Programme	<ul style="list-style-type: none"> ▪ Membership: 40 members (mixed men/women/youth) ▪ Registered: 2001; in operation for 4 years ▪ Activities: early child development programme (nursery school); HIV/AIDS awareness and counselling and home-based care; tailoring/dressmaking (awaiting funding from UNICEF to start); advocacy against child abuse; environment and sanitation (awareness on hygiene, drainage, and sewage disposal; piped water vending on commercial basis from water supplied through Nairobi Water & Sanitation Company (formerly NCC) ▪ Funding: Community Development Trust Fund (CDTF) funding for water activities; awaiting funding from UNICEF for tailoring/dressmaking activity.
BUM Self-help Group	<ul style="list-style-type: none"> ▪ Membership: 20 members ▪ Registered: 2000; in operation for 5 years ▪ Activities: environmental sanitation and cleaning ▪ Funding: contributions from members, well-wishers and friends
Mukuru Clean Environmental Self-help Group	<ul style="list-style-type: none"> ▪ Membership: about 8 women members + a few men ▪ Registered: newly registered; not active yet ▪ Activities: environmental cleaning
7. Sisal Zone	
Vision Sisters	<ul style="list-style-type: none"> ▪ Membership: 30 women ▪ Registered: 2004; active Catholic Church women group ▪ Activities: HIV/AIDS awareness; construction of toilets and sewage disposal; home-based care for sick people ▪ Funding: support from Catholic Church fathers; income from toilet run on commercial basis; members' contributions

Type of Organisation/ Name of Organisation	Details
Community-Based Organisation/	
7. Sisal Zone cont.	
Millennium Rehabilitation	<ul style="list-style-type: none"> ▪ Membership: (number not known) ▪ Registered: 2003; in operation for 2 years; active group ▪ Activities: training on maternal child care and midwifery; traditional birth attendants (TBAs) ▪ Funding: support from Catholic Loreto Sisters, who own Mater Hospital, St. Mary's Hospital (Langata) and dispensary (Mukuru kwa Njenga), and Nazareth Hospital (Banana)
Single Mothers	<ul style="list-style-type: none"> ▪ Membership: 25 members (women group) ▪ Registered: 2002; in operation for 3 years; active group ▪ Activities: own nursery school and primary school (Std.1-4); early childhood development programme (pre-unit); merry-go-round ▪ Funding: income from fees; members' contributions
Mukuru-Embakasi Self-help Group	<ul style="list-style-type: none"> ▪ Membership: 65 members (men/women) ▪ Registered: 1992; in operation for 13 years ▪ Activities: water projects; housing plots; welfare for burials, weddings, etc. ▪ Funding: profit/income sharing; government funding; bank loans
St. Mary's Self-help Group	<ul style="list-style-type: none"> ▪ Membership: 50 members (Catholic Church women group) ▪ Registered: 1989; in operation for 16 years ▪ Activities: social welfare for burials; loans to members ▪ Funding: support from church; members' contributions
8. Forty-Eight Zone	
Mukuru Integrated Young Girls	<ul style="list-style-type: none"> ▪ Membership: 40 members ▪ Registered: 2004; in operation for about 1 year; very active group ▪ Activities: community health work, HIV/AIDS; training in dress-making, catering; hair therapy ▪ Funding: World Bank - training on hair dressing/therapy
Kyeri Self-help Group	<ul style="list-style-type: none"> ▪ Membership: 40 members (men/women/youth) ▪ Registered: 2003; in operation for 2 years ▪ Activities: income-generating activities including dancing, piped water vending, posho mill through contributions; social welfare for burials, wedding, etc.; singing - Kikamba entertainment, songs, self-produced cassettes ▪ Funding: members' contributions, support from well-wishers and friends; applying for funding
Community-Based Organisation/	Mukuru Location Level
Mukuru CBOs Consortium	<ul style="list-style-type: none"> ▪ Membership: 20 CBOs ▪ Registered: 2005; based at Alice Health Services, Milimani Zone (see above) ▪ Activities: training on HIV/AIDS, providing home-based care for PLWA using volunteers; citizen awareness network comprising 12 member organisations which are involved in human rights, environment such as garbage collection, IGAs through empowering the community
Kenya Youth Concern Initiative	<ul style="list-style-type: none"> ▪ Membership: ▪ Activities: designs and implements programmes addressing social, cultural and economic issues affecting young people; uses Theatre for Development as its main dissemination tool re: HIV/AIDS and poverty

Type of Organisation/ Name of Organisation	Details
Non-Governmental Organisation/	
ANPPCAN (African Network for the Prevention & Protection against Child Abuse and Neglect)	<ul style="list-style-type: none"> ▪ Supports development project/activity - Community Organisation Training (COT) Programme to support community to form their own CBOs/Self-Help Groups ▪ Established project implementation office in MCC Zone in April, 2005 for duration of project life, expected to be 3 years
HCAP (Highlands Community Assistance Programme)	<ul style="list-style-type: none"> ▪ This NGO previously operated in the area having received funds from the National Aids Control Council (NACC) in 2003 to undertake activities re: HIV/AIDS. However, funds were misappropriated so the NGO "disappeared". Initially, its activities were of help to the community. It had a membership of between 50-100 (women/youth/men/tribe)
SIDAREC (Slums Information Development & Resources Centre)	<ul style="list-style-type: none"> ▪ Registered NGO: founded in 1996 based in Pumwani starting up in Mukuru kwa Njenga in 2000. ▪ Membership: 50 members; linkages with community weak and not very positive ▪ Activities: bakery, HIV/AIDS, early childhood programme (for street children), slums news magazine ▪ Funding: Ford Foundation
African Focus	<ul style="list-style-type: none"> ▪ Registered NGO/FBO: in 2000 ▪ Membership: 40 members; very active group ▪ Activities: HIV/AIDS, loans to members and women groups for poverty eradication ▪ Funding: Catholic Church, Spain
World Vision	<ul style="list-style-type: none"> ▪ Registered NGO: started projects in this area in 2003 ▪ Membership: 60 volunteers ▪ Activities: orphan sponsorship and support; cadets programme; loans to community groups for small micro-enterprises; donations to schools/facilities such as desks and stationery, construction of toilets and drainage systems; HIV/AIDS awareness programmes; removal of child labour ▪ Funding: external overseas bodies
Joy Women Group	<ul style="list-style-type: none"> ▪ Registered: 2000 ▪ Membership: 40 members; very active group ▪ Activities: housing, and buying and selling of plots; savings and loans to members ▪ Funding: support from politicians; members' contributions; loans from banks
The Marianists	<ul style="list-style-type: none"> ▪ Faith-based organisation under the Catholic Church ▪ Started its activities in 1989; very active and supports all members of the community ▪ Activities: runs a community polytechnic (Chaminate Training College); supports/makes donations to primary schools e.g. Our Lady of Nazareth Primary School, kwa Njenga Primary School (NCC), Mukuru Community Centre School; feeding programme in the schools ▪ Funding: Catholic Church, Ireland + support from politicians

Type of Organisation/ Name of Organisation	Details
Non-Governmental Organisation/	
Kayole Jua-Kali Association	<ul style="list-style-type: none"> ▪ Registered: (date unknown) ▪ Membership: majority of members resident in Embakasi area ▪ Activities: HIV/AIDS Prevention and Education under a Community Outreach Programme including VCT services for its members/others; dissemination of information on HIV/AIDS; skill upgrading programme for members, support to micro-credit programmes for low-income people; cyber café ▪ Funding: UN-Habitat (micro-finance programme); Konrad Adenauer Foundation (vocational skill training for young girls, etc.); NACC
Cana Family Life HIV/AIDS Programme	<ul style="list-style-type: none"> ▪ Registered: (date unknown) ▪ Activities: provision of medical care through free and voluntary HIV/AIDS testing and treatment of opportunistic infections; food and material support to orphans, PLWA + their children, single mothers and the very poor; home-based care; advocacy and mobilisation ▪ Funding:
Kituo cha Sharia	<ul style="list-style-type: none"> ▪ No specific details available
Development Partner/	
World Bank	<ul style="list-style-type: none"> ▪ No specific details available
UNICEF	<ul style="list-style-type: none"> ▪ No specific details available
Government Organisation/	
Nairobi City Council	<ul style="list-style-type: none"> ▪ Ward Office: for ward councillor and ward administration officer ▪ Activities: licensing of small-scale businesses; water and sewage services; garbage collection and environmental cleaning together with community groups; LASDAP projects ▪ Mukuru kwa Njenga Primary School
Provincial/District Administration	<ul style="list-style-type: none"> ▪ Chief's Office (for Mukuru kwa Njenga location) and Assistant Chief's Office (for MKN sub-location) ▪ Activities: run community policing programmes together with police and vigilante groups for security and peace within the community; dispute resolution; government policy dissemination
Embakasi Constituency AIDS Control Committee	<ul style="list-style-type: none"> ▪ Mobilisation of community groups to develop project proposals for accessing funds to address problem of HIV/AIDS ▪ Coordination of implementation of HIV/AIDS project activities
Ministry of Education	<ul style="list-style-type: none"> ▪ Embakasi Girls' Secondary School
Private Sector/	
Automobile Association of Kenya	<ul style="list-style-type: none"> ▪ HQ based in area since 2000
Barclays Bank	<ul style="list-style-type: none"> ▪ No specific details available
Mobil	<ul style="list-style-type: none"> ▪ No specific details available

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