

GHP 351 Final Paper (Spring 2010)
HIV/AIDS Intervention in a Squatter Settlement:
“Structural” Violence & The Culture of Neglect in Kibera, Kenya

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Honor Code: I pledge my honor that this represents my own work in accordance with University Regulations – Kok-Hou Chia

And while I stand in a place quite different than my own home and usual surroundings, the smell of Kibera is familiar to me. Garbage and sewage have a strangely universal stench. It's the rotten smell of things dead and finished, unwanted and wasted, stenches that cause me to recoil, reel, and pause a moment. Makuku motions with one hand toward the landscape as if he's unveiling the settlement before us. "Welcome to Kibera," he says.¹

This paper examines the provision of free HIV/AIDS treatment in a resource-poor and infrastructurally deficient setting, namely the Kibera slum in Kenya, considered to be one of the largest and poorest informal settlements in sub-Saharan Africa today. I begin by exploring the “structural violence” that victimizes slum-dwellers by understanding the legacy of crippling poverty left behind by Kibera’s colonial past. Next, I consider the most pressing infrastructural challenges faced by Kibera today, and connect these challenges to disease morbidity and mortality in the slums. I also look at the emergence of a public-private partnership between Medecins Sans Frontieres (MSF) and the Kenyan Ministry of Health in 2004 that expands access to free ARV treatment for Kibera’s residents. I look at MSF’s portrayal the beneficiaries of the treatment, and then complicate MSF’s “success” stories by looking at some of the documented challenges associated with HIV/AIDS treatment delivery in Kibera. I also draw on the insights of Professor Biehl’s *Will to Live* with regards to the challenges of ARV treatment delivery in resource-poor settings. I conclude by suggesting that systematic governmental neglect of the slums is an attitude that must be changed in order to reduce suffering in the slums.

¹ Mark Kramer, *Dispossessed: Life in our World's Urban Slums* (New York: Orbis Books, 2006), p.54.

Today, Kibera is sub-Saharan Africa's largest, most-densely populated urban informal settlement, and is still growing as a result of the ongoing influx of poor rural workers into Nairobi.² Located on the fringe of Nairobi, Kenya, it is severely overcrowded, and lacks basic amenities like electricity, clean water, and proper sanitation and sewage disposal facilities.³ Due to Kibera's "informal settlement" status, however, the Kenyan government is not legally obliged to, and so does not provide these vital services in Kibera. In the absence of governmental support, slum residents depend mostly on the sporadic efforts of nongovernmental organizations and other private enterprises to make these services available. In 2002, Andrew Harding, the BBC East Africa Correspondent in Nairobi, Kenya, describes Kibera as an "illegal squatters camp": "This place is like an island – it's not really part of Kenya at all. The state does nothing here. It provides no water, no schools, no sanitation, no roads, no hospitals. And why should it bother? As I said, this is an illegal squatters camp."⁴ The UN Office for the Coordination of Humanitarian Affairs comments on Kibera's geographical invisibility, "A dirty and forgotten place, Kibera does not appear on many maps, even though it is home to 800,000 people, or one-third of Nairobi's population."⁵

Today, Kibera is home to the poorest of Kenyans. Their present suffering can be traced to a larger historical pattern of systematic governmental neglect and social

² C. Unge and others, "Challenges for Scaling Up ART in a Resource-Limited Setting: A Retrospective Study in Kibera, Kenya," *JAIDS, Journal of Acquired Immune Deficiency Syndromes* 50, no. 4 (2009), 397-402, <http://search.ebscohost.com/login.aspx?direct=true&db=llh&AN=20093122200&site=ehost-live>; <http://www.jaids.org/pt/re/jaids/abstract.00126334-200904010-00008.htm;jsessionid=J24GM05yKLIQypLiQT5hphHGKPFrT4hKLLMDVJr2v0TyLZxGWclv!928310026!181195629!8091!-1>.

³ Wilson K. Gachiri, "Structures and Policies Influencing Healthcare Accessibility in Poor Urban Areas: A Case of HIV/AIDS, Tuberculosis and Malaria in Kibera, Nairobi, Kenya" US: ProQuest Information & Learning), p.48.

⁴ Andrew Harding, "Nairobi Slum Life: Into Kibera," *BBC News*, sec. Africa, 4 October, 2002, 2002.

⁵ "Kenya: Kibera, the Forgotten City," UN Office for the Coordination of Humanitarian Affairs, <http://www.irinnews.org/Report.aspx?ReportId=62409> (accessed 5/14, 2010).

marginalization. In order to understand Kibera's present woes, one must understand its colonial past, which reveals a history of racism and systematic marginalization of poor local Kenyans by their colonial masters. Journalist Mark Kramer notes, "For the most part, these settlements developed because colonial administrators developed Nairobi as a city, but to the exclusion of native Kenyans. Colonial officials allocated most land for personal benefit."⁶ Kibera began as a temporary settlement for Britain's colonial conscripts - a group of Nubian military veterans from Sudan – who eventually settled in Kibera after the First World War. As landlords, they rented out their land to the increasing number of migrant workers pouring into Nairobi from the countryside. Eventually, what was originally intended to be a temporary settlement evolved into the permanent homes of those who could not afford housing in the city.

By the 1950s, the British colonizers had racially segregated Nairobi, and Africans were prohibited from settling in the more economically prosperous areas of the city. Instead, the British officials pushed local Kenyans to the city outskirts.⁷ Moreover, the colonizers restricted Kenyans' economic activities, for instance, by prohibiting them from cultivating their own cash crops.⁸ The British settlers absorbed most of the economic wealth generated within Nairobi, thereby widening the economic gap between the alien settlers and the disenfranchised native residents.⁹ Nairobi's infrastructure was developed to cater to the needs of the foreign settlers. On the other

⁶ Kramer, *Dispossessed: Life in our World's Urban Slums*, p.58.

⁷ *Ibid.*, p.58

⁸ *Ibid.*, p.59

⁹ *Ibid.*, p.59

hand, roads connecting the natives to the city were not developed and maintained.¹⁰

Kramer describes the social marginalization of local Kenyans by the British:

Within a decade, the British effectively seized the most fertile highlands in the city and segregated Africans to designated regions...By 1963, the year of Kenyan independence, 70 percent of Africans in Nairobi were sequestered to the Eastlands, a municipality comprising just 10 percent of Nairobi's total land area. Other Africans lived in Kibera and other settlements.¹¹

Although the Kenyan government did attempt to implement a slums upgrading program in Kibera during the 1970s in order to improve access to clean water and electricity, the effort failed due to political problems. In the 1980s, the World Bank's structural adjustment policies severely compounded the economic problems of the poor slum residents.¹² In short, Kibera was plagued by a combination of oppressive colonial policies, failed governmental intervention, and unhelpful international economic policy. Today, Kibera's residents face a legacy of grinding poverty and debilitating disease in an environment of ongoing institutional neglect and social marginalization; they are victims of "structural violence," bearing suffering that can in part be linked to Kibera's colonial past, rife as it was with exploitation of the natives, as well as oppressive policies that bred poverty in the slum.

Today, as the slum continues to grow due to the large influx of migrants from the rural areas to Nairobi, its already overburdened infrastructure is facing increasing strain. Already in Kenya, 71% of urban residents, a majority of whom are unemployed and poor, reside in slums like Kibera.¹³ Overcrowding, and lack of drainage and sanitary systems have created an environment that is hazardous to human health. Kibera

¹⁰ Ibid., p.59

¹¹ Ibid., p.61

¹² Ibid., p.61

¹³ C. Kyobutungi and others, "The Burden of Disease Profile of Residents of Nairobi's Slums: Results from a Demographic Surveillance System," *Population Health Metrics* 6, no. 1 (2008), (10 March 2008)- (10 March 2008),

<http://search.ebscohost.com/login.aspx?direct=true&db=lhh&AN=20083208399&site=ehost-live;>

[http://www.pophealthmetrics.com/content/6/1/1.](http://www.pophealthmetrics.com/content/6/1/1)

lacks urban sanitation services (which the Nairobi City Council cleaning services do not cover). Consequently, human wastes are disposed of indiscriminately in open areas.¹⁴ The slum's 800,000 to 1 million residents share about 600 toilets. A common practice of waste disposal, namely "flying toilets," is widely used in which faeces are collected in plastic bags and thrown over rooftops at night. Moreover, pit latrines that are built too close to water wells have regularly caused contamination, leading to a high prevalence of water-borne diseases. The unhygienic conditions, according to a 2002 study, have led to a diarrhea prevalence of 36% among children below five years in the Kibera slum.¹⁵ According to UNESCO, 90 percent of the 1.8 million people worldwide who die of diarrhea every year are children below five years.¹⁶

Though Kibera's infrastructure is in shambles, it continues to suffer from intentional governmental neglect due to its "illegal settlement" status. This legal designation frees the Kenyan government from any obligation to provide basic services.¹⁷ Access to water is a major problem for the Kibera's residents. Since piped water is not provided by the government, slum dwellers often pay almost 8 times as much as city residents for their water. Even then, the water is of questionable quality. A slum resident comments that those who have access to piped water often exploit those

¹⁴ G. Gulis and others, "Health Status of People of Slums in Nairobi, Kenya," *Environmental Research* 96, no. 2 (2004), 219-227, http://search.ebscohost.com/login.aspx?direct=true&db=llh&AN=20043186288&site=ehost-live;http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6WDS-4BYR4D7-1&_user=10&_handle=B-WA-A-W-AZ-MSAYVW-UUA-AAUVVDUDBY-AAUWUCACBY-DYABDYWZW-AZ-U&_fmt=summary&_coverDate=10%2F31%2F2004&_rdoc=12&_orig=browse&_srch=%23toc%236774%232004%23999039997%235145931&_cdi=6774&_view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=a2297e655745cfff4ef568a49cd7da10.

¹⁵ W. N. Kung'u and others, "Diarrhoea Prevalence and Risk Factors in Slums," *Journal of National Institute of Public Health* 51, no. 1 (2002), 73-76, <http://search.ebscohost.com/login.aspx?direct=true&db=llh&AN=20023160375&site=ehost-live>.

¹⁶ Kenya: *Kibera, the Forgotten City*

¹⁷ Gachiri, *Structures and Policies Influencing Healthcare Accessibility in Poor Urban Areas: A Case of HIV/AIDS, Tuberculosis and Malaria in Kibera, Nairobi, Kenya*, 2873.

who don't, "Here there are no Nairobi City Council public water taps thus leaving us at the mercy of private tap owners and tankers... We have to queue for long hours to get water, and we buy it expensively."¹⁸

The acute infrastructural problems faced by Kibera as well as other Nairobi slums are compounded by the high prevalence of HIV/AIDS. The Kenyan government declared the AIDS a national pandemic in 1990. Though national infection rates rose to 10 percent in the late 1990s, they have been declining since then. Recent data suggests that the prevalence of HIV is estimated to be at 6.7 percent among the general population and 8.7 percent among high-risk groups.¹⁹ In response to this health crisis today, the National AIDS Control Council (NACC) of Kenya, which is part of the Kenyan Ministry of Health, coordinates over 200 centers in the country offering free antiretroviral therapy (ART).²⁰ However, although HIV/AIDS has been significantly linked to poverty which makes the slums extremely vulnerable,²¹ and although HIV/AIDS prevalence is believed to be far higher in Kibera than the rest of the country i.e. almost double the national average,²² the Ministry of Health, again part of the larger culture of governmental neglect and nonintervention, neither collects, nor maintains health or socioeconomic data related to the slums, Moreover, there is no reliable data management system in place to monitor the health status of Kibera's residents.²³

¹⁸ Ochieng Ogodo, "Kibera, the Forgotten Slums," East Africa in Focus,

<http://www.eafricanfocus.com/2010/03/21/kibera-the-forgotten-slums/> (accessed 5/14, 2010).

¹⁹ Gachiri, *Structures and Policies Influencing Healthcare Accessibility in Poor Urban Areas: A Case of HIV/AIDS, Tuberculosis and Malaria in Kibera, Nairobi, Kenya*, 2873.

²⁰ Ibid.

²¹ F. Ilako and Kimura M, "Provision of ARVs in a Resource Poor Setting: Kibera Slum, Kenya," Abstract. *International Conference on AIDS 15* (July 11-16, 2004).

²² Ibid.

²³ Gachiri, *Structures and Policies Influencing Healthcare Accessibility in Poor Urban Areas: A Case of HIV/AIDS, Tuberculosis and Malaria in Kibera, Nairobi, Kenya*, p.149.

Moreover, the Kenyan government does not maintain public hospitals in Kibera or in the other slums of Nairobi. Only when prompted by an international relief organization, namely Medecins Sans Frontieres was the government willing to step in to provide free ARV treatment in Kibera. A public-private partnership started in 2004 between Doctors Without Borders (MSF) and the Kenyan Ministry of Health expanded access to life-saving ARV treatment to Kibera's residents. In 2005, a third public health facility was built in Kibera South, with the goal, according to the MSF Head of Mission in Kenya, of proving "that it is possible to integrate HIV/AIDS care into primary health care. These three medical facilities deliver highly technical care and treatment ranging from simple HIV testing to putting patients on ARV drugs."²⁴ These services are provided at no charge to the slum residents. According to MSF's 2006/2007 International Activity Report,

The primary focus of MSF in Kenya is on treatment for people with HIV/ AIDS. In projects in the slums of Nairobi and in the rural areas of Busia and Homa Bay, MSF provides more than 12,000 people with anti-retroviral treatment (ART). Increasing emphasis is also being placed on an emerging and drug-resistant form of tuberculosis (TB).²⁵

A look at the way in which beneficiaries of the program have been portrayed reveals tendencies to hail the ARV treatment as a "magic bullet." In 2005, Medecins Sans Frontieres published photo-stories about Kibera residents who were enrolled in the ARV treatment program. MSF declares "the vast majority of patients who receive antiretroviral treatment can live in relative health and lead fulfilling and positive lives." However, the photo-stories either gloss over, or say next to nothing about the adverse

²⁴ "Nairobi Slums: Huge Need for HIV/AIDS Care," Doctors Without Borders/Medecins Sans Frontieres, http://www.msf.org/msfinternational/invoke.cfm?objectid=E0316006-E018-0C72-0953BD4A08A3DF1A&component=toolkit.article&method=full_html (accessed 5/14, 2010).

²⁵ "2006/2007 Report: Kenya/Doctors without Borders," Doctors Without Borders/Medecins Sans Frontieres, <http://www.doctorswithoutborders.org/publications/ar/report.cfm?id=2928&cat=activity-report> (accessed 5/14, 2010).

living conditions of the Kibera slum. Instead, they appear to hail ARV as the cure-all for the slum dwellers. Slum residents are portrayed to be helplessly afflicted before they started the treatment. The photo-stories then track the ways in which their lives are eventually transformed as they begin their ARV treatment and stay on track with their treatment. One patient, Siama, talks about her transformation from a helpless victim to a socially empowered individual thanks to the ARV treatment:

I first went for a test on the 3rd of January 1998. I didn't have any symptoms – I was healthy and happy – but I was worried about my ex-boyfriend so I decided to get tested...I got the result a week later. Positive. It was a very big blow – I was shocked. There was no counseling. I was told that I should just wait for months or a year. Then I should die...A friend of mine came and told me "Siama — you need to get real, you have to go to the district hospital". I didn't go. I told her "The hospital is for people with HIV and Aids; and I don't have Aids or HIV"...I started taking ARVs in April 2004 and after two months I felt fine...In fact, on the first day I started taking my pills, I picked up the first tablet and said to it "Please ARVs, I don't need any side effects, I just want to eat, sleep and plan for my future from now on!" I just live positively now. Since I've been on ARVs I have grown fat and beautiful! People sometimes ask "Are you really HIV-positive?"

Another HIV-positive patient, Charles, emphatically declares, "Things have changed so much for me in the last two years. I've gotten fat and I'm doing a busy job. I know that I will achieve whatever I want...It's all because of the drugs. If I had no been able to get free medicine from MSF, I don't know what would have happened."²⁶

In reality, however, HIV/AIDS treatment in a resource-poor setting like Kibera has turned out to be more challenging than expected, even when treatment is available for free. A recent 2009 study indicates that treatment adherence in Kibera is considerably lower compared with other studies from sub-Saharan Africa, with Kibera residents 11 times more likely to drop out of treatment than people who do not live in the slums.²⁷ Some reasons include the political insecurity and post-election violence of

²⁶ These stories can be accessed here: <http://www.doctorswithoutborders.org/photogallery/2005/world-aids-day/>

²⁷ Unge and others, *Challenges for Scaling Up ART in a Resource-Limited Setting: A Retrospective Study in Kibera, Kenya*, 397-402.

December 2007, which caused treatment adherence to plummet as residents did not want to risk getting caught in the thick of the violence while trying to get to the clinic.²⁸ Stigma and discrimination against HIV/AIDS sufferers in the slums are major barriers to effective treatment, causing slum residents to hide their seropositive status until their disease progresses to AIDS.²⁹ More interestingly, a considerable number of slum individuals have declined the free treatment offered by MSF, the most often cited reason being the “fear of taking medication on an empty stomach.” Apparently, patients were told by MSF health officials that a proper diet was needed for the drugs to be efficacious and to avoid side effects. But since many impoverished patients could not afford, or did not have food at home, they decided to forgo treatment thinking that the treatment wouldn't work given their circumstances.³⁰

In a recent newspaper article, a slum resident Violet Tinah told PlusNews:

When I went for the results that informed me that I had TB, I was very hungry; I'd had no breakfast and lunch and could barely walk...I had to be supported and put in a wheelchair to collect the drugs. Often I go without food and during such times I feel dizzy and nauseous after swallowing the [TB and HIV drugs. Putting food on the table is like a dream.³¹

Hunger was reported to be an acute problem in the slums, what with rising poverty levels and the recent rise in food prices in 2008. In 2009, the World Bank estimated that

²⁸ C. Unge and others, "HIV Treatment in Times of Civil Strife: Serious Threats to Antiretroviral Drug Access in the Kibera Slum Following the Kenyan Elections," *AIDS* 22, no. 13 (2008), 1693-1694, <http://search.ebscohost.com/login.aspx?direct=true&db=lhh&AN=20103019725&site=ehost-live;http://www.AIDSOnline.com>.

²⁹ M. A. Odindo and M. A. Mwanthi, "Role of Governmental and Non-Governmental Organizations in Mitigation of Stigma and Discrimination among HIV/AIDS Persons in Kibera, Kenya," *East African Journal of Public Health* 5, no. 1 (2008), 1-5, <http://search.ebscohost.com/login.aspx?direct=true&db=lhh&AN=20093013117&site=ehost-live;http://www.cabi.org/cabdirect/showpdf.aspx?PAN=20093013117;http://www.bioline.org.br>.

³⁰ C. Unge and others, "Reasons for Unsatisfactory Acceptance of Antiretroviral Treatment in the Urban Kibera Slum, Kenya," *AIDS Care* 20, no. 2 (2008), 146-149, <http://search.ebscohost.com/login.aspx?direct=true&db=lhh&AN=20083082432&site=ehost-live;http://journalonline.tandf.co.uk/link.asp?id=100631>.

³¹ "Hungry and HIV-Positive in Nairobi's Slums," *East Africa in Focus*, <http://www.eafricafocus.com/2010/03/10/hungry-and-hiv-positive-in-nairobis-slums/> (accessed 5/14, 2010).

the poor in Kenya spend on average 70 percent of their income on food.³² The chief of a village in the slums told PlusNews, “The slums have high HIV prevalence rates and without food there are challenges; our nurse has reported clients failing to collect ARVs on schedule – they say they are busy looking for work to buy food.” Food assistance programs, such as the Kenya Network of Women with AIDS, which supported 4000 HIV-positive slum residents, had had to be terminated recently due to lack of funding. Problems associated with poverty, such as hunger, clearly complicate HIV/AIDS treatment delivery in the slums.

Unhealthy sexual behaviors, which can be linked to the acute poverty in the slums, further exacerbate the HIV/AIDS crisis. A substantial volume of literature has shown that extreme poverty has forced many into the sex trade. Inequalities of power, associated with the various social “axes” of suffering, are present in Kibera. Regarding the axis of *gender*, Paul Farmer notes, “Throughout the world, women are confronted with sexism, an ideology that situates them as inferior to men.”³³ According to the 2007 Kenya AIDS Indicator Survey, a higher proportion of women aged 15-64 (8.7 percent) than men (5.6 percent) were infected with HIV, and 60% of HIV-infected Kenyans were female.³⁴ The extreme poverty of the slums means that women’s rights are violated more than ever, especially for economic ends. Parents, out of economic necessity and financial insecurity, often push their daughters into prostitution. Moreover, “To increase the likelihood that their sexual encounters yield profit, these young girls inevitably have to seek trysts beyond the deprived slums with wealthier men, who are likely to be older, more sexually experienced and, thus, more likely to

³² Ibid.

³³ Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, p.43.

³⁴ *Kenya AIDS Indicator Survey: Preliminary Report 2007* (Kenya: Ministry of Health, [2008]).

infect them.”³⁵ Extreme poverty, coupled with the axis of *gender*, predisposes these slum-dwelling girls to social suffering.

Surprisingly, although the Kenya National AIDS Strategic Plan (2009/10 – 2012/13) acknowledges the gender disparity in HIV/AIDS, the report goes on to state, “While prevention programs among young people have contributed to delaying sexual debut and increasing risk perception, for young women who are already sexually active, prevention programs have failed to make a major difference.”³⁶ This report does not appear to recognize the full reality of the problem, and seems to take for granted the human agency of the young women who, despite knowing about the health risks to which they are exposing themselves, are often forced by their poverty and economic conditions into prostitution.

The axis of *location* plays a part in the social suffering of the slum-dwelling poor. The slum-dwellers, despite being full Kenyan citizens, are denied access to essential public services simply because they live in an area designated by the state as “illegal,” a legal appellation that sanctions government inaction, and justifies the denial of municipal services. Moreover, besides economic factors, the social and housing conditions unique to the impoverished slums also encourage more sexual activity. Young children are socialized into sexual behavior from an early age because they live in huts with no partitioning walls, and are inevitably exposed to their parents’ sexual activity. Moreover, there are few or no alternative recreational activities. Further still,

³⁵ F. N. A. Doodoo, E. M. Zulu and A. C. Ezeh, "Urban-Rural Differences in the Socioeconomic Deprivation - Sexual Behavior Link in Kenya," *Social Science & Medicine* 64, no. 5 (2007), 1019-1031, <http://search.ebscohost.com/login.aspx?direct=true&db=lhh&AN=20073056795&site=ehost-live;http://www.sciencedirect.com/science/journal/02779536>.

³⁶ *Kenya National AIDS Strategic Plan (2009/10 - 2012/13)* (Kenya: National AIDS Control Council,[November 2009]).

adults themselves hardly provide healthy role models for young children as they are often involved in prostitution and casual sex. Poverty is the underlying factor of many of the social problems faced by the slum residents.³⁷

Second only to HIV/AIDS, violence contributes the most to the burden of mortality of two Nairobi slums, a recent study indicates. This violence can be attributed to an insecure environment, which is again the result of governmental neglect and marginalization. The failure of the government to provide a police force and a justice system to maintain social order has resulted in the adoption of “mob justice” as the rule of law in the slums, which is often meted out even for trivial crimes.³⁸ The study reveals the ways in which social factors contribute to this violence:

The most common modes of injury are gunshot wounds, road traffic accidents and blunt trauma during mob justice. The modes of injury reflect the high levels of insecurity and violence in the population. Informal settlements are characterized by living and social conditions which are known risk factors for violence. At the society level, they include reduced inhibitions against violence, and the creation and sustenance of gaps between different segments of society. At the community level, social disintegration, high residential mobility, high population density, heterogeneity and lack of social cohesion play a role. At the individual level, low educational attainment, drug and alcohol abuse, and unemployment are important. Most, if not all, of these factors are present in informal settlements and hence the high level of interpersonal violence is unsurprising.

The social problems of insecurity and violence, as well as drug abuse and low level of education are, unsurprisingly, problems associated with poverty. In Professor Biehl’s research into the Brazilian AIDS policy, his ethnography shows that the marginalized urban poor are enmeshed in broken social structures that impair their *will to live*. His ethnography reveals the full complexity of HIV/AIDS as a disease with social dimensions, and that it is not just a biological affliction. When HIV-positive patients are evicted from Caasah due to governmental regulations, they are ejected into a dismal

³⁷ Dodoo, Zulu and Ezech, *Urban-Rural Differences in the Socioeconomic Deprivation - Sexual Behavior Link in Kenya*, 1019-1031.

³⁸ Kyobutungi and others, *The Burden of Disease Profile of Residents of Nairobi's Slums: Results from a Demographic Surveillance System*, (10 March 2008)-(10 March 2008).

social environment ravaged by grinding poverty, drug abuse, prostitution, and violence, which negatively impact HIV/AIDS treatment adherence. Moreover, a culture of nonintervention by government officials has left the responsibility of taking care of the marginalized urban poor on under-funded grassroots organizations and NGOs. A culture of nonintervention clearly persists in the slums of Kibera as well, and slum residents face more or less similar social problems (with poverty as the underlying factor) as the urban poor described in Professor Biehl's study.

As mentioned earlier, recent research has shown that treatment adherence is particularly low in Kibera in general.³⁹ This should not come as a surprise, as the situation is similar among the marginalized urban poor in Brazil. Professor Biehl's ethnography reveals the complexity of providing HIV/AIDS treatment for the marginalized urban poor. ARV treatment may work for the middle and upper classes who enjoy relatively stable social environments that make treatment adherence easier, but this is not so for the urban poor. In the case of the Brazilian AIDS policy, Professor Biehl notes, "How much additional effort is required to transform drugs that are "accessible" into drugs that are both present and effective in the everyday lives of poverty stricken patients."⁴⁰ A local Brazilian doctor, Dr. Nanci remarks about a poor patient, "To live is too complex and, in comparison, the world of drugs is an easy way out for all parties. So she will come back...and die, not of AIDS, but of drug abuse."⁴¹ Professor Biehl notes that beyond prescribing drugs, there is a need to pay attention to the health facilities and active care approaches that are available for the poor:

³⁹ Unge and others, *Challenges for Scaling Up ART in a Resource-Limited Setting: A Retrospective Study in Kibera, Kenya*, 397-402.

⁴⁰ Joao Biehl, *Will to Live: AIDS Therapies and the Politics of Survival* (Princeton and Oxford: Princeton University Press, 2007), p.388.

⁴¹ *Ibid.*, p.350

“Yes, distribution programs make antiretroviral therapies accessible, but they are one element in the full treatment of a disease that, as the health secretary made clear in his statement, remains a matter of a regional politics of nonintervention. Beyond the mere distribution of drugs, there is a need for clinics and treatment centers, for active approaches to providing care. Here, grassroots initiatives and patients themselves are overburdened with this task, and as AIDS spreads amid misery, entrance into treatment programs is restricted, under the name of providing quality care.”⁴²

In the final analysis, as far as this paper’s scope of exploration is concerned, the level of governmental neglect of Kibera, extending from colonial times to the present day, is astonishing given the relatively high HIV/AIDS prevalence in Kibera compared to the rest of Kenya. The government, by designating the slums as “illegal settlements,” has managed to absolve itself from providing basic services to Kibera so that today, the state of the infrastructure in Kibera is in dire conditions. The government collects little or no health data on the vulnerable slum dwellers. In the absence of state intervention, Kibera residents have come to rely heavily on the assistance of local NGOs and nonprofits for the provision of basic services. However, when lack of funding causes these programs to be closed down, the residents are mostly left without an alternative line of social support. To date, there has been little effort on the part of the state to look into the problems of the slum dwellers beyond the provision of free ARV treatment in collaboration with a few NGOs.

Moreover, tendencies to promote ARV treatment as the “magic bullet” exist in Kibera. As we have seen, contrary to MSF’s convictions of success, poverty in fact complicates the HIV/AIDS treatment delivery for many of the slum dwellers. Many impoverished patients have declined the free HIV/AIDS treatment due to their lack of access to food. On top of that, the slum dwellers have to deal with adverse social conditions caused by poverty, such as violence, drug abuse, prostitution etc. They are

⁴² Biehl, *Will to Live: AIDS Therapies and the Politics of Survival*, p.348.

victims of “structural violence,” and unless the governmental neglect of Kibera is seen as a problem and overcome, and unless the government takes concrete action to commit itself to upgrading the slums facilities beyond the provision of ARV treatment, suffering is likely to persist in Kibera. Like Brazil, I think Kibera is yet another example of where the government might have failed its poorest citizens.

Today, the world’s poor are the chief victims of structural violence – a violence that has thus far defied the analysis of many who seek to understand the nature and distribution of extreme suffering. Why might this be so? One answer is that the poor are not only more likely to suffer; they are also less likely to have their suffering noticed...No honest assessment of the current state of human rights can omit an analysis of structural violence – Paul Farmer, *Pathologies of Power*⁴³

⁴³ Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, p.50.

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