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HIV and Young People

Risk and Resilience in the Urban Slum

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Preface

This paper reviews the major findings regarding HIV and vulnerability. The fact is while global trends in HIV infection have diminished, some 30 years on into the epidemic, and a plethora of research that has guided policy and action, HIV remains a major threat to health and livelihood. The evidence amply demonstrates the multidimensional nature of HIV and the never static face of risk and resilience to infection and treatment uptake and the consistent vulnerability of certain groups often marginalised and disempowered. Gaps in the evidence emerge as fresh insights, and conceptual understandings develop and open up new areas of enquiry, along with global and contextualised changes in demographics and epidemiology, at the forefront of which is urbanisation and the informal slum settlement.

Sub-Saharan Africa carries the heaviest burden of HIV and takes its heaviest toll among young populations, as it has since the outset. Reflecting global trends, the continent is becoming younger. As cities in sub-Saharan Africa, and across the world, become increasingly youthful, young people are disproportionately impacted by HIV and routinely perform poorly across a wide spectrum of health indicators. As such, an association has been made between exponential urban growth and HIV infection. Young people hold the key in understanding where we are and where we expect to be in controlling global and urban epidemics, yet the least gains are being made in regard to young people, especially, concerning their sexual and reproductive health.

Much of the vulnerability of young slum dwellers, it is argued, owes to the subjective experience of humiliation felt at a deep level that impacts risky behaviour within the broader structural universe of informal settlement residence – poor shelter, violence, material deprivation, suboptimal health services and regular dislocation. Whereas the literature has comprehensively explained risky and health-enhancing behaviour largely through cognitive and social theory, the case is still being made in discerning young people's behaviour as a considered resilience, of purposeful behaviour aimed at dignifying life in the present and making good in a neglected and deprived environment. Such resilience may not be conceived or wish to be perceived as rational or productive. Life for young slum inhabitants by necessity is shown to be experimental in nature and has at its core immediate and diverse forms of gratification.

The connection between urban slum residence and perceptions of vulnerability, risk and resilience to HIV infection among young people residing and migrating to informal settlements is the broad area of interest for this review. This review examines HIV infection in a rapidly urbanising world and draws extensively on examples taken from Nairobi, Kenya and sub-Saharan Africa. Kenya now sits at the crossroads and is poised to become one of the few countries in the world to control its HIV epidemic. A focus on the national capital, Nairobi, provides an excellent example of how the future response to HIV will need to accommodate new forms of city space, deal with the rising number of young urban dwellers as well as the drastic intra-urban differences in slum and non-slum HIV prevalence and contextualise a response that can unravel the complexity of a mature, generalised and concentrated epidemic. For the purposes of in-depth analysis, it is also one of the few cities in sub-Saharan Africa that has provided insightful slum surveillance data of relevance to urban centres across the continent.

The literature review is structured as follows: section one is an introduction to the critical issues; section two sets the scene by exploring the literature on the subject of health and wellbeing, sexual and reproductive health in a rapidly urbanising world, including the structural determinants of health in urban slum settings, and the major theories which have sought to explain it; section three focuses on HIV within urban contexts globally, in sub-Saharan Africa and particularly in urban Kenya; section four reviews the available literature on youth vulnerability to HIV in the urban slum and explores the key dynamic of gender and gender relations; section five presents the case for urban migration and the very special set of needs and vulnerability faced by the legions of young people taking up residence in the urban slum; and section six concludes by outlining the most pressing gaps in the evidence as demonstrated from the literature and identifies research priorities required to significantly address these shortcomings.

Cairns, QLD, Australia Gary Jones

Keywords HIV • Urban slums • Vulnerability and risk • Resilience • Dignity and humiliation • Self-perception • Risky behaviour • Sub-Saharan Africa • Kenya

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About the Author

Gary Jones is a research scholar at the Cairns Institute, James Cook University, studying for a Doctorate in Philosophy (Society and Culture), 2014–2017.

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Chapter 1
Introduction

Abstract This chapter provides a broad overview of the key issues regarding HIV and young people in the context of African urban slum life, in particular, conceptual understandings of vulnerability, risk and resilience and the interpersonal role of dignity and humiliation in shaping perception and behaviour.

Keywords HIV • Urban slums • Vulnerability and risk • Resilience • Dignity and humiliation • Self-perception • Risky behaviour • Sub-Saharan Africa • Kenya

Vulnerability, Risk and Resilience

Vulnerability is a complex construct. Complex because its conceptual understanding is never absolute and evolves overtime, between social groups and according to context. Vulnerability is a relative state, a multifaceted continuum between resilience and helplessness (World Bank 2015) and given meaning through subjective perception (Kahneman and Krueger 2006). For this paper, vulnerability is defined as the degree to which a person is susceptible to HIV infection. A person's vulnerability is determined by a combination of biomedical and behavioural factors, including physiology, gender, age, education and peer influence, and it is shaped by the totality of the external environment (Cluver et al. 2014).[1]

For this literature review, risk is defined as exposure to the HIV and probability of infection. Whereas vulnerability involves external structural factors largely beyond the control of the individual, 'taking risks' refers more to purposeful behaviour, of individual agency, and the likelihood of acquiring HIV through a given event or series of acts.[2] The risk of HIV infection is affected by factors of vulnerability and the consequences of a given act. The two positions are inextricably linked.

[1] Vulnerable has been defined as: '... open to attack, injury or criticism...' (*The Little Oxford Dictionary* 1998, p. 745).

[2] Risk has been defined as: '...chance of danger, injury, loss...' (*The Little Oxford Dictionary* 1998, p. 559).

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In being vulnerable, there is always the probability of a negative (health) outcome. Vulnerability and risk are rooted in a significant lack of welfare that goes beyond socially accepted norms and is shaped by an episode or series of events in which the result is not certain (World Bank 2015). The magnitude, frequency, duration and scope of risk and stress, as experienced by individuals, households and communities, form the structural basis of vulnerability (Ludi and Bird 2007). Much of the research accepts that vulnerability is a multilayered phenomenon and best understood through two interlinked sides representing external and internal factors as made clear by Chambers (1995). The former side refers to exposure to shocks, stress and risk and the latter, a basic defencelessness and incapacity to act without incurring damage or loss (Chambers 1995).

Throughout the literature, the concept of vulnerability is entwined with notions of risk and resilience, which is oftentimes not made explicit. Furthermore, resilience is often associated with notions of dignity, in particular, how certain behaviour serves to dignify life and wellbeing for an individual or community. What the literature does not make clear is the many and often conflicting perceptions of dignity and health, born in part from a multitude of interpretation of what is vulnerability and what is risk, and, furthermore, what actually constitutes 'health'. Being vulnerable, for most of the literature, implies a state of dependency, which may not be reliable or consistent, and therefore inherently 'undignifying'. Dignity and resilience are often seen as highly emotive terms and can blur the rigours of academic enquiry. In this review, in depicting the social universe for young slum dwellers, where necessary, a distinction is made between the numerous constructs relevant to a discussion of vulnerability, risk and resilience.

The literature has highlighted the need to distinguish between self-perceived risk and self-perceived vulnerability (Bradley et al. 2011). Self-perception of risk is best understood as the likelihood of becoming HIV infected based on knowledge and behaviour, and self-perceived vulnerability concerns felt susceptibility to HIV even in the absence of risk behaviour (Bradley et al. 2011). Though interwoven, the constructs of risk and vulnerability and the role of self-assessment are key to understanding subjective interpretation and behaviour patterns regarding the transmission of HIV (Bradley et al. 2011). Far less explored is the self-assessment of dignity and humiliation by vulnerable young slum-dwelling populations in the context of risk, resilience and HIV.

HIV, Risk and Resilience

No one is immune to HIV (Power 2013). Everyone is vulnerable to contracting HIV; the question is to what extent. For people accessing and using the full gamut of prevention, treatment, care and the extensive range of support services, the likelihood of acquiring HIV is perceived, for the better part, as an 'acceptable risk' (Hunter and Fewtrell 2001). The literature demonstrates that for many slum-dwelling inhabitants of sub-Saharan Africa, where HIV and AIDS have from the

outset exacted its greatest toll, vulnerability and risk compound and that knowledge, perception and purposeful action against acquiring HIV remain limited.[3]

Individual and collective resilience, here, is the ability to safeguard against (re-) infection or recover from the outcome of risky behaviour, of being HIV positive and of navigating the uncertainty of social change in the face of hardship, set back and threat to life and livelihood.[4] As Lever states (2010), effective personal resilience is sustainable over time and enables individuals to draw on vital resources including external means of support. In response to threat, perceived or actual, the evidence demonstrates that negative coping mechanisms are often deployed by different groups at different times and in different circumstances which, while dealing with the immediate problem, put at risk long-term health and wellbeing (Degenova et al. 2010). This choice of action can also be understood as an attempt to salvage a sense of dignity in the face of uncertainty, want and resignation.

Constructing conceptual understanding of vulnerability, risk and resilience is an integral part of modelling health and wellbeing at all levels of service delivery. Underpinned by theoretical persuasion, modelling formal and informal health care reflects an understanding of the nature of and motive for patterns of human behaviour (United States Department of Health and Human Services 2002). In some cases, either wittingly or unwittingly, these models draw on principles from different perspectives of social theory. Arguably, this is not surprising as efforts continue to craft an 'ideal type' of risk and behaviour and to more comprehensively profile modern urban vulnerability.[5] The efficacy of mainstream approaches of both health education and health promotion has been questioned in the face of a continuing HIV epidemic which can, in essence, be controlled if not eradicated (Joint United Nations Programme on HIV/AIDS (UNAIDS) 2014b).

Broadly, two principal health models, social learning theory and the structural-environmental paradigm, have formed key theoretical perspectives in explaining reproductive and sexual behaviour (King 1999). In practical terms, these positions are not mutually exclusive (United States Department of Health and Human Services 2002). Sexuality and risky behaviours, as best described by structural-environmental

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[3] 'HIV stands for 'human immunodeficiency virus'. HIV is a virus (of the type called retrovirus) that infects cells of the human immune system (mainly CD4 positive T cells and macrophages—key components of the cellular immune system), and destroys or impairs their function. Infection with this virus results in the progressive deterioration of the immune system, leading to 'immune deficiency'. The immune system is considered deficient when it can no longer fulfil its role of fighting off infections and diseases. Immunodeficient people are more susceptible to a wide range of infections, most of which are rare among people without immune deficiency. Infections associated with severe immunodeficiency are known as 'opportunistic infections', because they take advantage of a weakened immune system…AIDS stands for 'acquired immunodeficiency syndrome' and is a surveillance definition based on signs, symptoms, infections, and cancers associated with the deficiency of the immune system that stems from infection with HIV' (UNAIDS 2008, p. 1).

[4] Resilient has been defined as: '…recovering from setback' (*The Little Oxford Dictionary* 1998, p. 550).

[5] 'Ideal type, in the social sciences, refers to an artificially constructed 'pure type' which emphasizes certain traits of a social item which do not necessarily exist anywhere in reality' (McLeish 1993).

theory, are based in individual, social, structural and environmental factors that provide a framework, inter alia, for analysing the context of adolescent reproductive behaviour (McLeroy et al. 1988; Sweat and Denison 1995). Work on identifying core drivers of vulnerability has been informed by the study of dignity and humiliation (Hartling et al. 2013; Lindner 2012). This work notes the pervasive impact of humiliation and related self-conscious emotions, in particular, 'shame', experienced as an interpersonal and inter-relational event and its impact on risk-taking behaviour.[6] However, as proponents state, the empirical base is still lacking and requires further investigative work and especially so across diverse settings (Hartling 2005; Shultziner and Rabinovici 2011).

Research into dignity and humiliation needs to first unravel the complexity of urban life. The nexus of vulnerability, risk and resilience has been captured by the World Health Organization (WHO) and the United Nations Habitat agency (UN-Habitat) through the development of a framework for the study of urban habitation. The framework sees each aspect largely determined by a complex mix of physical, emotional, social and economic factors which can be understood from four classifications relevant to urban wellbeing: first, 'natural and built environment'; second, 'social and economic environment'; third, 'food security and quality'; and fourth, 'services and emergency health management' (WHO and UN-Habitat 2010, p. xi). The framework provides a classification for the study of dignity and humiliation in which the multiplicity of factors directly relating to health and wellbeing are understood by analysing the dynamic relationship and influence that each part holds over the other.

Young People, Urbanisation and HIV

For HIV and AIDS, understanding the link between young people's vulnerability and their sexual and reproductive health is paramount. Young people, of all age cohorts, are at the centre of the HIV epidemic with the primary mode of transmission, across Sub-Saharan Africa, being heterosexual sex (Mberu 2012).[7] Young people below the age of 25 now account for around 50 per cent of all new global HIV infections, and in many developing countries, notably sub-Saharan Africa, as much as 60 per cent of all new infections are among the 15–24 age group with females greatly outnumbering males and, in some contexts, by a factor of 2:1

[6] Humiliation has been defined as 'causing someone to feel ashamed and foolish by injuring their dignity and self-respect' (*Oxford Dictionaries*, Oxford University Press, 2015); and dignity has been defined as 'the state or quality of being worthy of honour or respect' (*Oxford Dictionaries*, Oxford University Press, 2015).

[7] For young people, age group conceptualizations are: 'childhood,' any person under the age of 18 (United Nation Human Rights Office of the High Commissioner for Human Rights (UNOHCHR) 1989), 'adolescence' referring to the age group 10–19 years (WHO) and 'youth' the 15–24 age group (political instruments of the United Nations); young people, less formally defined, include both adolescents and young adults, the 10–24 age group (Mberu 2012).

(Mberu 2012). Women below the age of 25 years are at most risk of contracting HIV; in sub-Saran Africa, adolescent girls are the most vulnerable to HIV and account for one in four new HIV infections (UNAIDS 2014a). For urban women, HIV is 1.5 times higher than for urban men and 1.8 times higher than rural women (WHO and UN-Habitat 2010). Whereas there is an overall global decline in AIDS-related deaths, UNAIDS reports that adolescents are the only age group in which AIDS-related deaths have not decreased (UNAIDS 2014a). This situation is striking not just for public health but also for the threat to inalienable human rights given that HIV-positive adolescents require lifelong treatment and must prepare to face the various forms of humiliation owing to the stigma of simply being HIV positive.

HIV continues to threaten lives of individuals and their livelihoods, the security of families, however defined, and wellbeing of entire communities (UNAIDS 2014b). In Africa, the leading cause of death for adolescents is AIDS related; globally, it is the second highest cause of death for the same age group (UNAIDS 2015). In Kenya, an estimated 17 per cent of all AIDS-related deaths are among adolescents and youth (Ministry of Health, Kenya 2012).[8] HIV discriminates against most vulnerable populations – vulnerable because of circumstance, personal traits, disposition, social networks and structural determinants (United States Agency for International Development (USAID) 2012). These vulnerable or 'key populations' are the focus of concerted global action to reduce global HIV incidence. The evidence shows that many key populations concentrate in urban environments (UNAIDS 2014c). Their vulnerability and resilience are not static but evolve according to context, time and place. Daily life, often described as 'survival' for many of these marginalised groups, is learned in situ as well as how to gain an advantage often against overwhelming odds.

Urban Slums as Settings for Risk and Vulnerability

Urban spaces are expanding and patterns of urban life constantly change. Seen as the engine for industrialisation, economic development and social advancement, urban centres are best seen as a 'blessing and a curse' given that within the urban context there are concentrations of poverty, slum growth and social disruption (United Nations Fund for Population (UNFPA) 2007). Vlahov et al. (2007) have described the urban slum as a 'concentration of disadvantage' in which population-level patterns of sickness and health are routinely formed by structural factors. As such, slum settlements reflect the urbanisation of poverty and constitute

[8] 'In epidemiology, prevalence refers to the proportion of a population having an identified condition, such as HIV/AIDS. Through comparing the total number of people with that condition and number of people in that population group the extent of prevalence can be determined; incidence is a measure of the risk of a condition developing in a specific period of time' (Sifiris and Myhre 2015).

ever-evolving urban 'risk spaces' (Fitzpatrick and LaGory 2000). Humiliation, it is argued, feeds off such situations of poverty and disconnection (Lindner 2009, 2012). There are, however, gaps in the empirical evidence on how this sense of poverty and entrapment is internalised and given expression especially in the African slum. Whereas consistent exclusion from social services is well noted as a factor leading to humiliation and shame (Lindner 2006), its effect on vulnerability in the urban context still needs to be developed through concerted empirical evidence. Moreover, much of the research into urban vulnerability is still dominated by an approach which adopts an economic analysis of poverty and in so doing fails to appreciate the complex reality of poor people which is by essence diverse, dynamic and multifaceted (Chambers 1995).

It is reckoned that approximately 54 per cent of the global population now lives in urban settings (United Nations 2014). With annual growth rate of urban dwellers at 3.4 per cent between 2005 and 2010, and 4.8 per cent in 2013, Africa is growing at a pace unrivalled elsewhere in the world (Aribisala 2013; Hove et al. 2013). In Sub-Saharan Africa, it is estimated that between 2000 and 2013, the urban population would double (UNFPA 2007). Within Africa, East Africa provides the most extreme case of population growth with one of the highest growth rates in the world (Aribisala 2013). In Kenya, the population is expected to grow from the current 43 million to more than 100 million by 2050 (Aribisala 2013). In sub-Saharan Africa, nearly half (45 per cent) of people living with HIV now reside in urban areas (UNAIDS 2014c). Based on global estimates of demographic trends and patterns of infection, ending AIDS, it is now widely held, will largely be won or lost in the cities.

The demographic profile of urban populations is changing and, in Africa, becoming increasingly younger. Africa is believed to have the youngest population in the world with an estimated 200 million Africans between the ages of 15–24. In Kenya, 43 per cent of its population is under 15 years (Aribisala 2013). This has been described as the Youth Bulge[9] (Sommers 2011). By 2030, it is estimated that approximately 60 per cent of all urban dwellers will be under the age of 18 (UN-Habitat 2014a). Population dynamics changes the shape and creates new forms of urban risk and vulnerability. Mberu (2012) note that research is being challenged to keep apace of these developments, and particularly so regarding attitude and behaviour among urban youth. The literature reveals that insight into the subjective interpretation of vulnerability and resilience remains wanting overall, and notably so for urban youth.

In understanding the drivers of HIV, 'place matters' (UNAIDS 2011b). The place of residence, work and social mixing, along with age and gender, provides the global framework for understanding and addressing vulnerability, including HIV infection (WHO and UN-Habitat 2010). Place is shown to be a major determinant of health and wellbeing in a myriad of ways. Areas with the poorest health out-

[9] In many sub-Saharan African countries, young people represent the majority share of the population pyramid. The term 'youth bulge' is often used in the context of 'social instability', given the lack of appropriate age-friendly social services and economic opportunities.

comes are those where the poorest people live and work (WHO and UN -Habitat 2010). Descriptive statistics on the epidemic only have meaning when sufficiently disaggregated, especially concerning gender, age and location. But, as the literature shows, this is very often not the case in national and subnational records on HIV and AIDS. Much of the demographic and ethnographic data on urban settings do not take into account profound differences between slum, intra-slum and non-slum settlement, a situation described as the 'curse of aggregates' (Lamba 1994). The literature broadly holds that there will be little progress in improving health outcomes in urban settings without first providing detailed and disaggregated data inclusive of socioeconomic profile and geographical areas involving applied research targeting the different forms of urban slums.

As UN-Habitat states (2007), sub-Saharan Africa urban growth is driven by expansion of the different forms of slum settlement.[10] For many least developed countries, rapid urbanisation is largely owing to exogenous factors and not a natural, evolutionary movement towards modernity (Jorgenson and Rice 2012). As Arimah's research shows (2010), a large part of the urban poor is increasingly found in the various types and forms of slum settlements. In Africa, 55 per cent of all urban-residing populations now live in a slum (UN-Habitat 2014b). The fact that a higher than expected proportion of people inhabits urban areas relative to concurrent levels of economic development has been described as 'over-urbanisation' (Smith 1987). In terms of unearthing the reality of life in the slum, data collection still proves a global challenge not least as most of the available information on slum dwellers needs further disaggregation (UN-Habitat 2007).

Cotton (2013) explained how life in the slum is harsh with residents facing multiple hazards to health shaped by factors of age, gender, ethnicity, race and/or disability and socio-economic status. Slum areas are typically characterised by exclusion, including lack of land rights and access to infrastructure, public facilities and basic services (UN-Habitat 2011). Unlike their urban counterparts, slum dwellers are largely excluded from the 'urban advantage'[11] and instead face persistent challenges of unemployment, pollution, traffic, crime, high cost of living and competition over scarce resources (UNICEF 2012). The literature, however, fails to adequately depict how these same residents seek to realise their personal sense of 'urban advantage' and in so doing dignify their life in the slum nor has research holistically and consistently enquired into possible links between dignity, resilience and social status. The innovation of slum-dwellers and the strength of their social capital is a significant but often neglected feature of urban studies (UN-Habitat 2006b). Empirical enquiry that explores the notion of seeking dignity through inno-

[10] For this review, unless otherwise specifically stated by a cited source, the words slum and informal settlement are used to refer to all types of suboptimal living conditions.

[11] The concept of urban advantage holds that cities are the main setting for progress and that the urban space facilitates the advancement of political ideas and action and provides unlimited benefits for the best level of health, education and public services, like adequate supplies of water and sanitation.

vation and initiative notably for young people is weak and overwhelmingly missing in the research of African urban slum life.

Slum-dwellers, and especially those living in extreme poverty, have been variously described as 'populations of humanitarian concern' because for many securing the basic necessities to sustain life and livelihood is never certain. In the urban setting, populations of humanitarian concern are heterogeneous and include long-term multi-generation residents, economic migrants, internally displaced persons and refugees fleeing humanitarian crisis (International Office for Migration (IOM) 2011). Given the continuing exponential growth of cities, the United Nations International Strategy for Disaster Reduction (UNISDR 2014) points to the evolving urban dynamic as critical for global efforts in disaster risk reduction. Moreover, given current patterns of urbanisation and in particular the unplanned urban settlement, it is held that vulnerabilities to loss of life and livelihood and attrition of social, economic and environmental assets are expected to continue and likely increase (UNISDR 2014).[12] This assumption has immediate implications for discussions on sociopolitical power dynamics as well as the role of social capital in accessing life-saving resources, all of which are shown to be core components for managing vulnerability and reducing risk. The sprawling urban settlements of Nairobi are a case in point.

As the evidence demonstrates, in eastern and southern Africa, slum inhabitants face vast health inequities, as well as heightened vulnerability to a wide range of disease and illness, including HIV (WHO and UN-Habitat 2010). In the Nairobi slums, the average HIV prevalence for women aged 15–49 years living in a non-slum area is 8.4 per cent, while the same cohort living in the slum is 12.4 per cent; similarly for men of the same age group, prevalence in the non-slum is 2.9 per cent, and for men residing in the slums, it is 5.7 per cent (Africa Population and Health Research Centre 2014; Kenya National AIDS & STI Control Programme and Ministry of Health 2013; Madise et al. 2012). For all of Nairobi County, adult preva-

[12] For UNISDR (2012), the 'Ten Essentials for Making Cities Resilient' are '1. Put in place organisation and coordination to understand and reduce disaster risk, based on participation of citizen groups and civil society. Build local alliances. Ensure that all departments understand their role in disaster risk reduction and preparedness. 2. Assign a budget for disaster risk reduction and provide incentives for homeowners, low-income families, communities, businesses and the public sector to invest in reducing the risks they face. 3. Maintain up-to-date data on hazards and vulnerabilities, prepare risk assessments and use these as the basis for urban development plans and decisions. Ensure that this information and the plans for your city's resilience are readily available to the public and fully discussed with them. 4. Invest in and maintain critical infrastructure that reduces risk, such as flood drainage, adjusted where needed to cope with climate change. 5. Assess the safety of all schools and health facilities and upgrade these as necessary. 6. Apply and enforce realistic, risk-compliant building regulations and land use planning principles. Identify safe land for low-income citizens and upgrade informal settlements, wherever feasible. 7. Ensure that education programmes and training on disaster risk reduction are in place in schools and local communities. 8. Protect ecosystems and natural buffers to mitigate floods, storm surges and other hazards to which your city may be vulnerable. Adapt to climate change by building on good risk reduction practices. 9. Install early warning systems and emergency management capacities in your city and hold regular public preparedness drills. 10. After any disaster, ensure that the needs of the affected population are placed at the centre of reconstruction, with support for them and their community organisations to design and help implement responses, including rebuilding homes and livelihoods'.

lence is estimated at 8 per cent, compared with 6 per cent for the rest of the country (APHRC 2014; Madise et al 2012; Nairobi City Council 2014).

Approximately 34 per cent of Kenya's population now lives in urban areas, and more than 75 per cent reside in informal settlements that occupy some 5 per cent of the total land mass (APHRC 2014; Integrated Regional Information Networks 2013; UN-Habitat 2005). These slum areas have rarely figured in urban plans and largely go unrecognised, growing spontaneously on available land inside the city or on its outskirts (Pamoja Trust 2009). For Pamoja Trust (2009) it is a straightforward case of disenfranchisement and alienation of slum dwellers. Exclusion, experienced personally or collectively, for Lindner (2010), is very often a precursor of humiliation. Kenya's annual informal settlement growth rate is estimated at 5 per cent, making it one of the highest in the world and the number of urban slum dwellers is expected to double over the course of the coming 15 years (UN-Habitat 2005).

Nairobi, Kenya

Strongly influenced by factors of migrancy, trade and commerce, the HIV epidemic in Kenya, the fourth largest in the world, is closely linked with that of sub-Saharan Africa, which accounts for almost 70 per cent of the global total of new HIV infections annually (UNAIDS 2014a). Nairobi provides an excellent case study of African urban risk and development. With a population of around 3.36 million estimated in 2011, Nairobi, the second largest city by population in the African Great Lakes region, contributes to approximately 60 per cent of the country's GDP and is growing at 2.9 per cent per annum (Central Intelligence Agency 2015). Nairobi, the nation's capital, is a hub for business enterprise, for health innovation, and is described as a leading African city, both politically and financially (Bauck 2015). Nairobi is equally seen as a leading social centre in the region (Global and World Cities 2015).

While Nairobi is home to much wealth and economic activity, there is also conspicuous inequality and it has two of Africa's three largest slums – Kibera and Mathare (UNAIDS 2014c). With a notable lack of equity in Kenya, and particularly in Nairobi, it was earlier reckoned that one-third of Kenya's urban population was living below the national poverty line (UN-Habitat 2006a). In its global report (2006b), UN-Habitat stated that the Kenya Gini Coefficient is 0.45 and in Nairobi 0.59 and that inequality is more pronounced in Nairobi than elsewhere in the country, with an estimated 45 per cent of Nairobi's income going to 10 per cent of the city population and the poorest 10 per cent sharing in 1.6 per cent of the total city's income (UN-Habitat 2006a). A sense of resignation from living in extreme poverty can be a factor leading to humiliation owing in part to notions of powerlessness in not being able to alter individual or community circumstance which can lead, in turn, to episodes of physical and mental illness (Lindner 2010).

Kenya is home to tens of thousands of migrant and mobile populations including refugees and internally displaced people, housed in formal camp settings, or more informally across the country and often in urban centres, notably Nairobi. In Kenya, the total 'population of concern' stands at over half a million people (United Nations Office for the Coordination of Humanitarian Action (UN/OCHA) 2015).

Neighbouring countries include Somalia and South Sudan, categorised as 'very high-risk' states (Haken et al. 2014) and currently characterised by cyclical violence, social upheaval and mass displacement of people across international borders. It is thought that about two-thirds of the refugees and asylum seekers in Kenya have fled general insecurity in their respective countries of origin since the 1990s (UN/OCHA 2015). South Sudan is suspected of having an emerging HIV epidemic (Sudan Tribune 2014) which has immediate and long-lasting implications for the AIDS response in Kenya. Each person caught up in displacement and involuntary movement has an account of personal and institutional vulnerability and a sense of resilience having made it this far.

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