A Qualitative Assessment of Support Mechanisms in Informal Settlements of Nairobi, Kenya

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ABSTRACT. Urban poverty in sub-Saharan Africa is highly concentrated in an increasingly isolated segment of the population living in sprawling slum settlements and shanty towns of most cities. The extreme deprivation in these areas poses serious survival challenges that these people have to grapple with daily. This paper explores informal support mechanisms used by the urban poor in dealing with three main challenges: lack of food, illness and bereavement. It is based on forty focus group discussions conducted in four slum communities in Nairobi, Kenya. The findings show that community members, despite their crippling poverty, extend support to others when faced with serious problems that go beyond what may be considered general or commonplace. The study makes a strong case for development and implementation of public safety nets accessible to the poorer segments of the urban population.

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Some studies suggest that informal support arrangements are ineffective in economically constrained settings such as during wars, drought/famine, natural disasters, and in poor urban settings. In poor urban communities in particular, it has been noted that traditional support mechanisms provided by the extended family may be non-existent and where they exist they may become easily overwhelmed (Wratten, 1995; Hamid, 1996; Potts, 1997; Booth et al., 1998; Moser, 1998; Meikle, 2002). Moser (1996) has argued that community adjustment to economic crises depends on the material well-being and coping ability of the community, and that communities have a certain threshold beyond which they break down. The term community is used here to refer to people who reside in a geographically defined area, who identify with that area and share an interest in its betterment (Grant, 2001; Yap, 1989).

Unlike developed countries that have public safety nets to mitigate major problems, most countries in Africa do not have such systems. In Kenya, for instance, people tend to rely on personal resources such as savings, sale of physical assets and reciprocal exchanges to solve their own problems (Morduch, 1999; Besley, 1995). When such personal resources are exhausted or when faced with problems for which such resources are grossly inadequate, people turn to the extended family, friends, workplace, community and other informal networks for support. The government's intervention is visible only during extreme crises such as drought/famine (in form of food aid), disease outbreaks (e.g., cholera, typhoid, and malaria) or flood disasters.

Some studies suggest that social capital and networks exist and perform important roles in poor urban communities including the provision of material and emotional support to needy members (Dersham & Gzirishvili, 1998; Meikle, 2002). The willingness of urban poor residents to look beyond their own needs and difficulties and assist non-kin community members in dire situations stands out very significantly as an expression of communal spirit in these settings. This paper therefore explores residents' perceptions regarding the level of community support towards three problems: lack of food, illness, and bereavement. The in-depth qualitative data provide insights into the perceptions of poor urban communities on when and how to extend the required support to needy members. Previous research has shown that informal cop-

ing strategies often fail when problems arise abruptly or are extreme. We do not know how well such informal coping strategies function when problems are too common or generalized within the population. In this paper we examine how well informal support mechanisms work in poor urban communities. We start from the premise that informal support mechanisms reflect the conscious choice of individual community members to provide assistance to others as they balance their own persistent needs with those of kin, friends, neighbors and other community members.

URBANIZATION AND POVERTY

A key feature of poverty in Africa is the high degree of exposure and susceptibility to the risk of crisis, stresses and problems with little capacity to recover quickly from them (Rakodi, 2002). A number of studies suggest that poverty in urban areas has begun to successfully challenge rural poverty leading to what many term as the urbanization of poverty (Potts, 1997; World Bank, 2001). Amidst the difficulties experienced by individuals, the process of urbanization has generally been thought to lead to a new form of social organization that is incongruent with traditional forms of family relations and modes of production. According to Davis (1937) urbanization forces individuals to cooperate with countless persons who are not kinsmen, encouraging them to join special interest groups to meet their various social and economic needs. While urbanization in most of sub-Saharan Africa is not typical of Davis' urban-industrial-mobile society construct, the question remains regarding the forms and functions of social support extended through relations and networks that exist in the most deprived settings of urban areas in Africa.

SLUM COMMUNITIES/INFORMAL SETTLEMENTS IN NAIROBI

The proliferation of informal settlements in urban areas in Kenya has been identified as one of the main causes of increasing levels of environmental degradation, and deteriorating public health standards. Informal settlements refer to both squatter settlements where housing units have been constructed on land to which the structure owners or occupants have no legal claim, or which they occupy illegally and areas

where housing structures are generally not in compliance with current planning and building regulations (United Nations, 1996). These areas generally lack basic amenities such as water, electricity, waste disposal and government services such as health facilities and schools. According to a recent survey of Nairobi slum communities, only 24% of the households in such settlements have access to tap water (whether public or piped into their residence) compared to 92% for Nairobi as a whole. And only about 18% have electricity compared to 60% for the city as a whole (APHRC, 2002). These residents generally suffer high levels of unemployment leading to low income and poverty that further limits their access to health, education, and opportunities for self development. It is estimated, for instance, that 32% of Nairobi residents are economically inactive (Republic of Kenya, 2002). Many of the city's residents are therefore engaged in informal income-generating activities and casual labor in the industrial areas. A high percentage of Nairobi residents (about 60%) live in slum communities, which occupy about 5% of the residential land area (APHRC, 2002). The majority of slum residents' household income ranges between KShs. 2,000 to 3,000 per month (US $27 to 40) (Mwangi & Foeken, 1996; Foeken & Mwangi, 2000). Many of these people live and work in unhealthy, polluted, and risky environments (World Bank, 2003), in congested areas characterized by makeshift structures, some self-made with carton boxes, polythene papers, metal sheets, tins, and mud.

A study conducted by APHRC (2002) established that children in the slum communities have lower survival chances compared to their counterparts in other areas of the country, including rural Kenya. For instance, the under-five mortality rate is over 150 per 1000 live births in these areas compared to 112/1000 for Kenya in general and 113/1000 in rural areas. The prevalence of diarrhea among children under 3 years of age was 30.8% in the slums compared to 17.1% for both rural areas and Kenya as a whole. The percentage of children under three years with fever was estimated at 68% in the slums compared to 42% nationally and in rural Kenya. The levels of urban food poor increased from 29% in 1994 to 38% in 1997 (Government of Kenya & United Nations, 2003). Although it is not possible to estimate the prevalence of lack of food in slum communities, predictors of nutritional status indicate high prevalence of food-related deficiencies. A study conducted in Korogocho found that two-thirds of the population was unable to meet daily energy requirements, 40% of the children aged between 6 months and 5 years were underweight, 28% were stunted and 5.4% were wasted (Mwangi & Foeken, 1996).

STUDY SETTING

The data used in this paper have been derived from an exploratory study of informal settlements in Nairobi conducted by the African Population and Health Research Center (APHRC) in 1999. One of the aims of the study was to establish the extent to which the living conditions in the informal settlements influenced community support. The study was conducted in four communities namely Embakasi, Kibera, Majengo, and Kahawa North. These sites were purposively selected from a list of 19 slum communities documented in the 1989 census data. The selection criteria aimed to maximize diversity in the 19 informal settlements with respect to ethnic, gender, and age compositions, marital status, population size, and geographic representation.

METHODS

Forty focus group discussions (FGDs) were conducted, ten in each of the four selected study communities. Twelve fieldworkers were engaged for the study, 3 in each site (one male and one female moderator, and a note-taker). The fieldworkers were all experienced in qualitative research. Prior to fieldwork they were trained on the basic principles of qualitative research and the study objectives. They participated in the translation of the FGD guide into Kiswahili–the national language of Kenya, and in pre-testing the guide. The FGD participants comprised males and females of different age categories (13-17 years, 18-24, 25-49 and 50+) along with mixed groups of community leaders and service providers. In total 328 people participated in this study.

The discussions, which took one and a half hours on average, were tape-recorded and transcribed by the fieldworkers at the completion of fieldwork. All the FGD transcripts were coded according to themes developed based on the FGD guide utilized for data collection. The analysis was done using NUDIST. Descriptive data have been generated for use in this paper. Quotes are presented as a way of giving the people a voice on the issues discussed.

FGD is an important methodology for qualitative research. It is useful in understanding group views and perceptions and provides an overview of community-wide sentiments on a given issue. Such sentiments, however, may often reflect common stereotypes rather than the individual beliefs and experiences of the participants. One key weakness of FGDs is the inability to quantify how widespread the views expressed

by the group are in the general population. Although as sources of data they may stand alone, views expressed during FGDs may guide the design of interventions or quantitative studies.

RESULTS

A total of 26 groups discussed the issue of community support with regard to the three problem categories. There were striking similarities in the nature of support mechanisms reported across the four communities and across groups defined by age and gender with respect to food and funeral problems but some differences with respect to illness and hospitalization as shown in Table 1.

Twenty-four (24) out of the 26 groups reported help during bereavement. The other two groups, females aged 13-17 and service providers, did not discuss support during bereavement even though they discussed community support in general. Of significance is that fourteen of the groups reported community support does not exist for lack of food. The three groups that reported support with food qualified this by indicating that such support usually comes from charitable organizations and religious groups and targets special groups such as the elderly and children. When such support comes from other community members, it is often out of sympathy rather than an obligation. Generally, the female discussants provided more detailed discussions on support mechanisms than male groups. Other types of support mentioned by the discussants in-

TABLE 1. Community support for lack of food, illness and bereavement.

Need	13-17 M	13-17 F	18-24 M	18-24 F	25-49 M	25-49 F	50+ M	50+ F	Community leaders	Service providers	Total
Lack of food	- - +	- +		- -		-	-	- - - +	-	- - -	3+ 14-
Minor illness	- +	-		- - +			+	+			4+ 4-
Major illness	- +	-		- ++	+	+	+	++	+	+++	12+ 3-
Death	++	+++	++	++++	+	++	++	++++	++	++	24+ 0-

Key: + number of groups that reported provision of support
- number of groups that reported lack of support

cluded fundraising for weddings and when houses are destroyed by fire. What the analysis suggests is that the study communities have unwritten codes that guide their actions during a crisis. In general, while there is no "organized" assistance in the form of public safety nets and formal private insurance to help families cope with emergencies, there is almost always community assistance to members who are bereaved. Such community assistance, however, is rarely extended when individuals or households are faced with hunger or lack of food as discussed below.

Assistance with Food

Many households are often faced with acute food shortages and can go without food or with just one meal a day for several days. For instance, APHRC (2002) found that 8% of adolescent boys and girls had only one meal the day before the interview. Some women may engage in survival sex just to be able to afford food for themselves and their children. While it is unclear how pervasive these conditions are in the slum communities of Nairobi, this section explores perceptions of the respondents regarding community support in circumstances where members are faced with acute food shortage and hunger.

Across the four communities, gender, and age groups, the discussions consistently show that no form of support exists for individuals or households who lack food and sometimes residents can go for days without food:

> *#4 "But not problems to do with food."*
> *#3 "If it is sickness or death that is where we help. Even when someone wants to marry we also help."*
> *#1 & #5* (together) *"But for food, it is every man for himself."* (Embakasi, Males 50+)

In expressing similar sentiments, a group of young females in another community noted that:

> *#1:"When it comes to funeral expenses people come together and raise the money. But if it is food it is up to the individual person concerned."*
> All Respondents [In Chorus]: *"Eeeh."* (Kahawa North, Females 18-24).

The responses by the participants suggest a general willingness to support others however lack of food is a common problem facing every household. In some informal settlements there are however exceptions to this general rule. Such exceptions, rather than being an expected form of support, depend more on the benevolence of individuals, some NGO activity in the community, or occur during festive occasions and are clearly targeted at specialized marginal groups such as children and the elderly. A group of community leaders provided insights on this type of support:

> *This assistance is very different . . . but there are those who are extreme. They have nothing. They have no business and they have children . . . there are people who care for them . . . even though people do not help each other seriously, there is a section we have taken the responsibility of helping. They are extremely poor. For these ones, we have the Catholic association of sisters that makes sure they collect* (maize) *flour from Lang'ata at least twice a week. At least these ones get some assistance even though it is little . . .* (Kibera, Community leaders)

A woman in a 25-49 age group expressed this exception to food support as:

> *#3 "You can get some sympathetic people. A woman may just look at the children and have mercy. She will dip in her pocket and remove probably the remaining twenty shillings and buy food for these children. You cannot look at a child starve. When you think of your own children, you feel sympathy."* (Kahawa North, Females 25-49)

It is important to note that despite the widespread poverty in these communities, community members pointed out that there have not been instances of whole households starving to death. This implies that individuals and households are somehow able to adjust to not depending on the community for food support:

> *Here we haven't heard of somebody who has been defeated completely . . . except for disease. You know if someone sells "sukuma wiki"* (kales) *and she is sick to the extent that she cannot wake up, that is when we can help. But for surviving there is none who has been completely unable.* (Embakasi, Community leaders)

An elderly woman reported that she tied a piece of cloth around her stomach to stop hunger pangs, which illustrated that community members may generally resign to their own fate in the face of hunger.

Assistance with Sickness or Hospitalization

As illustrated in Table 1, when it comes to sickness and hospitalization, as a rule of thumb, community assistance is garnered mainly for serious illnesses that require or result in hospitalization. This may probably be due to the fact that in such deprived settings individuals are always "sick" (as they are always hungry) and unless an individual's case is worse than the average sickness, no external assistance is rendered. Poor urban dwellers are known to be concentrated on polluted land or physically dangerous sites which are close to industrial waste outlets, toxic waste dumps and contaminated water courses. As a result, they perennially suffer from diseases such as typhoid, diarrhea, cholera, malaria and worm infestation (Meikle, 2002:40). Except for some communities where NGOs provide medical assistance, community members receive virtually no assistance for medication against minor ailments. This view was articulated by a group of young women (18-24 years) as follows:

> *#2 "Because if you went to tell someone that your child is like this* (unwell), *he/she will tell you that even he/she has a problem."*
> *#1 "Even me I have a problem, I'm not married. . . . I have children . . . just so many things. There is no way that he can help you."*
> *#2 " . . . if you tell them to give you fare to take your child to hospital, they will tell you that even they haven't taken breakfast. So, when you are told that, what do you do? You just keep quiet."*
> (Embakasi, Females 18-24)

Another group observed that:

> *#1 "People only come to one's aid if it is serious sickness but these small ones they do not bother. When you are sick and in bed then people will raise money and hire a vehicle to take you to hospital."*
> (Kahawa North, Females 18-24)

Assistance during major illness or hospitalization is often in the form of contributions for hospital bills, mobilizing transportation for patients to go to hospital, and providing them with food. Such assistance is also

based on reciprocity and on the strength of an individual's social networks. Friends, neighbors and relatives are called upon to help and therefore they form part of the patient's or caregiver's social support network. They also rally around the patient/caregiver in mobilizing support from the wider community. Interestingly, fundraising efforts initiated by the patient or his/her household are generally not taken seriously and no one, except close friends and relatives, would contribute to them. Community participation in fundraising for hospitalization increases when friends or neighbors take the initiative. This is where maintaining social networks becomes crucial for individuals' survival in the community, as in any other setting. Those with limited social networks within the community are least able to access such assistance when in critical need. Community members fully understand these unwritten codes of conduct in accessing support. As one man in Embakasi put it:

> *#1 "I cannot go to anybody's house and say that I need help. They will say I am a conman. I may have malaria and I am really badly off, even if I ask you to contribute money for me to go to hospital, you will not, so I have to go and ask my friends. . . ."*

Across discussion groups participants underscored the view that individuals' ability to create and maintain social networks was important in accessing social support. The ability to interact, support and cooperate with others determines the type and level of support extended to the person in need:

> *#1 ". . . Your friends and maybe relatives will contribute. But friends are more involved."*
> *#2 "It depends on how well you make friends. There are some people who do not talk to anyone. Such people will be sick in their houses and people will not know about it. But if you talk to people, it will be easier for you to be helped and be taken to hospital."*
> (Kibera, Males 18-24)

Some participants, however, expressed the view that community support during illness and hospitalization is a thing of the past, maybe due to general deprivation in the community, as noted by a group of 50+ males:

> *#1 "Now for diseases you help yourself, if you die inside the house it is okay."*

> *#4 "Even food it is the same."*
> Respondents (Chorus): *"It's like that."* (Kahawa North, Males 50+)

Some NGOs were mentioned as providing *ad hoc* assistance to community members with regards to medication and hospitalization. Help is also extended by religious organizations such as the Catholic Church and Mosques as mentioned by a group of women participants in Majengo:

> *#1 "If it is on the side of medicine, people do get assisted by Undugu Society* (local NGO) *and the Catholic Church. There is a nurse who pays home visits to treat those who are sick but unable to go to hospital. The Catholic Church gives* (maize) *flour to those who are sick, they also give medicine. If you go to Undugu Society and you have a prescription they send you to Jamia Mosque Chemist, with which they have an agreement. After getting the medicine it is Undugu Society that will pay."*
> *#2 "We have a clinic by the Latin Community which also assists us here nowadays."* (Majengo, Females 50+)

Suffice to note here that while some conditions such as fever, coughs and diarrhea may appear *too common* and innocuous at their early stages, delayed treatment is oftentimes fatal. The lack of support in such instances may be at the root of the high mortality observed among children in the slum communities.

Assistance During Bereavement

Residents of the study communities are most able to access support during bereavement. Such support may sometimes be based on ethnic, religious, and social ties but at other times it cuts across such boundaries:

> *#1 "We donate money towards funeral expenses."*
> *#2 "What we do as Muslims, if you are bereaved and you lack money you will have to see the Imam who will donate the money for the funeral expenses because money has been set aside for such expenses. . . ."* (Majengo, Females 25-49)

Another group of young men noted that:

> *#1 "Like in Churches, if such a thing happens, people will unite and help each other."* (Majengo, Males 13-17)

Strategies often adopted for fundraising during funerals include going from door to door throughout the community and neighboring areas to ask for donations or playing music to attract people so that they could contribute towards the funeral. This general fund-raising strategy is known as "harambee" (pulling together). Some of the strategies used are captured in the following quotes:

> *#1 "So people moved from house to house including to the other ridge until they got enough money, that is, until they raised KShs. 3000.00* (in reference to a specific case in the past)." (Kahawa North, Females 25-49)

A group of young girls in Kibera reported that:

> *#1 "Yeah, they play music at night and when people come they contribute money."*
> *#2* "*There is another one* (strategy) *I heard . . . these girls who like going out at night. The girls are put at a place and men are told to contribute, may be ten shillings, to dance with them. . . . "* (Kibera, Females 13-17)

Again, as with illness and hospitalization, friends are the ones who initiate and implement such fundraising activities although the occasion generally attracts people from far. In some cases, however, funeral contributions follow ethnic or religious cleavages rather than involve entire communities as expressed by some groups:

> *#3 "And we contribute on ethnic lines. We don't just contribute . . . the Luo contribute their own style, Kikuyu their own style, Kamba their style. . . . "*
> All Respondents: *Eh . . .*
> *#1 "If somebody is your friend you contribute for him. When we are in the Church we have all ethnic groups . . . we contribute all of us. . . . We don't say that is a Kikuyu who died. . . . "* (Kibera, Service Providers)

The money collected during a funeral is generally used to buy a coffin, hire a vehicle to transport the remains to the ancestral home or to the

mortuary, buy food for the mourners and for other funeral-related expenses:

> *Let's say someone has died and has no finances, people go for the funeral planning meetings and they contribute. . . . If the family does not have a coffin, they buy the coffin, if it is a vehicle to take his body home* (if he comes from far) *they contribute.* (Embakasi, Females 18-24)

While contributions are generally voluntary, in some instances, a fixed amount is levied or expected from the immediate neighbors, those who live on the same plot or those who go to the same Church with the deceased or from members of self-help groups as noted by several groups:

> *Let us say you stay in a plot and share a gate, all the tenants are told to contribute KShs. 10.00 each. The money will accumulate to a good amount. That is how we try.* (Kibera, Males 18-24)

A group of young women noted that:

> *There are those who have joined committees* [self-help groups]. *The committee could contribute a particular share to help them.* (Kibera, Females 13-17)

A group of community leaders noted that:

> *Take for example what this woman has told you that women and even men form groups where they contribute money. . . . This money helps the members very much with their daily financial needs. For example somebody may have a sick person or may be bereaved, the members of this group come together and contribute ten shillings or twenty to help this person*. (Kibera, Community Leaders)

The above information indicates that death remains a centripetal force in social relations even in informal settlements. Bereavement is the only problem that inspires community-wide support unlike lack of food and minor illnesses which are fairly commonplace and largely considered individual responsibilities.

DISCUSSION AND CONCLUSION

An important feature of the social organization of slum communities and indeed of most African communities is interdependence in times of need, which is generally referred to in this paper as an informal support mechanism. Such support may provide poor individuals and households with access to loans, childcare, food, accommodation among other services (Moser, 1998; Dersham & Gzirishvili, 1998). The traditional norm of reciprocity and the expectations/obligations of mutual aid which it engenders have to some extent survived the difficult environments within which residents of informal settlements live. However, it is acknowledged that the ability to call on social networks vary and may breakdown because of repeated problems, economic crisis or physical insecurity (Rakodi, 2002; Moser, 1996; Booth et al., 1998).

The social support discussed by the study participants seems to confirm what Durkheim (1933) calls organic solidarity. He distinguishes between the mechanical solidarity of traditional communities and the organic solidarity of modern societies involving cooperation between unlike individuals and groups. The FGD participants seem to place emphasis on friends who could be drawn from the neighborhood, Church/Mosque or the workplace. Several types of social networks, which appear to be fairly complex, were mentioned by the study participants including family members, kinsmen (ethnic groups and clans), work colleagues, friends, neighbors, and charitable individuals/organizations (Phillips, 2002). Religious groups emerged as important in supporting their members when in need, especially when bereaved and to a less extent when seriously ill. The study participants indicated that they access assistance from other parts of the city, from former residents and other acquaintances or go beyond the poor–non-poor divide and capitalize on strong social alliances such as religious and clan affiliations (Tacoli, 1998; Meikle, 2002; Phillips, 2002).

This study has shown that an individual has specific responsibilities towards his/her own well-being and that of his/her household. Lack of food being a common problem in these communities and one which individuals endeavor to resolve on a daily basis is not considered a crisis. This observation is not unique to this group of people. In *Voices of the Poor* (World Bank, 2003), a young man from Zambia observes that when food was in abundance relatives used to share it but things have changed due to food shortages to the extent that even relatives do not assist. Beattie (1964) cites a range of anthropological literature in the pre-colonial period that link kinship, political, and economic organiza-

tion to meet individuals' needs collectively, especially the poor, old, and frail. However, such support is reported to have started changing as structural poverty levels increased in the post-colonial period (Iliffe, 1987).

Illness is a problem that community members saw as *too common* and therefore not deserving of community-wide intervention. Illness is however distinguished in terms of severity–minor illnesses are commonplace and therefore the responsibility of the individual/household. On the other hand, serious illnesses that require hospitalization sometimes evoke community support. Such support may be availed to a household which has lost all its property in a fire while it may not be readily available to someone who has been ill for a long time or for problems that are prevalent in the community.

Why do community members look beyond their daily survival needs during bereavement as opposed to when there is lack of food and illness? Although their study focused on rural areas, Lund and Fafchamps (1997) observed that informal support mechanisms helped with funerals but not with pressing issues like crop failures, mild illness, or unemployment. There are several factors that may account for this bias among our study population. Many people in the study communities, and indeed in most African communities, believe in life after death and therefore contributions to the death process may be a result of shared norms and societal values. Given the common belief in the active participation of ancestral spirits in the lives of the living such contributions may be seen as an insurance cover against negative influence from the dead and the search for a positive interaction (Middleton, 1965; Amuyunzu, 1998). In addition, the death of a community member may serve to remind the living of their mortality and therefore evoke more sympathy through acknowledging that they will also die and that they would hate to be left alone if they lost one of their household members. Focusing on bereavement could be a trade-off aimed at maintaining social networks amidst daily struggles of the poor (Phillips, 2002). Further, people are more aware of death than illness and lack of food that happen to be commonplace among the urban poor.

A study conducted in Kagera on HIV/AIDS (World Bank, 2001) established that medical expenses were generally overshadowed by funeral expenses. Only 40-50% of the non-bereaved households received cash or in-kind assistance from others compared with 80-90% of the households that suffered a death. This is also evident from this study as shown in Table 1: support during bereavement was reported by 24 groups compared to 3 and 4 for lack of food and illness, respectively.

Only 12 groups reported support during major illnesses, half the number that mentioned support during bereavement. Although death has always been a centripetal force in African and other cultures (Middleton, 1965; Amuyunzu, 1998), our study findings in an urban poor setting show that it is still one of the binding cords of the social networks even amidst poverty and across diverse cultural groups. What emerged during this study were the different mechanisms used to raise money during bereavement. Strategies that include the setting up of funeral committees and dancing parties indicate the people's social adaptation to their environment which is mainly cash-based.

When the study participants note that support is dependent on how the person has been helping others, it is implicit that such support is mutual: "help me now and I will help you tomorrow in equal measure." Although support from NGOs and other charitable entities is critical for the poorer members of the communities that may be excluded from social networks (Beall & Kenji, 1999), it is also conditional. One has to participate in certain activities to access such support. This places the onus on the individual–it is his/her responsibility to inculcate trust and a relationship with members of whatever network he/she belongs to in order to access the necessary support. This system of mutual obligation and support may be at the core of the survival of communal spirit in poor urban settings. The study also affirms that reciprocity and co-operation are key aspects of social support (Morduch, 1999; Durkheim, 1952). The suspicious nature of the informal settlement dwellers also calls for members to be cautious in their dealings so that genuine need is not interpreted as extortion for funds. For instance, the fundraising has to be organized by friends rather than family members of the affected person(s) to realize the target because the residents know that a desperate person will utilize desperate means to survive.

The support provided by self-interest groups (such as rotating credit associations, welfare groups, etc.) has not been fully explored in this paper although its functions were alluded to by the study participants (Cattell, 2001). However, its benefits are often limited to its members and their close associates. As suggested in this study, the poorest people in these informal settlements who lack means to meet their basic needs of food, shelter and healthcare may choose to suffer in silence rather than be seen as lazy or incapable. Given the reciprocal nature of communal support in these settings, the poorest people may also be least able to develop the social networks necessary for accessing communal support. Our data does not allow us to provide specific examples of such

cases and therefore there is need for a study focusing on the poorest of the poor who may be excluded from the forms of informal support mechanisms discussed in this paper. They may have lower access to support even when faced with bereavement or they may have other forms of support that may not have been captured.

In conclusion, this study has shown that when problems are too common people tend to consider them individual responsibilities (e.g., lack of food and minor illnesses) but readily assist on major problems that they perceive individuals are not able to tackle on their own (e.g., major illnesses and bereavement). However, such distinction between what individuals are expected to take care of on their own often makes no exceptions with respect to the capacity of a particular individual or household to cope with such a problem. The fact that such support is reciprocal may alienate those who are unable to extend similar support to others. Kenya does not have a public social support system which implies that those who are disadvantaged may be worse off even among the urban poor. There is therefore a need for public safety nets that would enable community members to contribute to other people's needs and therefore become integral parts of the support networks which perform critical roles in enabling members to cope with major problems.

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