Access to Basic services

The Health Status of the Urban Poor in Kenya

Policy Brief
August 2015

Background

Understanding and identifying ways to address the poor health outcomes among the urban poor is central to Kenya's economic development.

Evidence from the first Nairobi Cross-sectional Slum Survey (NCSS) conducted in the city by the African Population and Health Research Center (APHRC) in 2000 revealed that slum residents have the worst health outcomes of any group in Kenya (including rural residents)[1-5]. They have limited access to basic facilities such as water and sanitation, or opportunities for life such as education and employment, and that they endure the near absence of the public sector and law enforcement agencies in their daily lives. These conditions not only expose slum residents to poor health outcomes 1 but also foster social unrest and violence[6].

This policy paper presents findings from two rounds of NCSS carried out in 2000 and 2012 respectively to study the changes in access to basic services and the health profile of the Nairobi slum dwellers. The evidence presented here will inform programs and actions geared towards improving the lives of the urban poor, not only in Nairobi County and other urban counties.

KEY POLICY MESSAGES

- The absolute number of urban slum dwellers will continue to grow in Kenya requiring in sustained investments to achieve Vision 2030 and the Sustainable Development Goals.
- The health of slum residents has improved, but their averages sill remain well below that of Nairobi and Kenya.
- Several opportunities are being missed.
    - Higher ANC coverage is not translated into the recommended 4 ANC visits.
    - The high coverage for BCG is not translated into full immunization
- There are also disparities between Nairobi slums and the central division is consistently worse-off highlighting the need for a targeted approach complemented by demand side interventions.
- Regular collection of disaggregated data is important for informed policy making.

Access to water and sanitation

Figure 1 shows that access to water and sanitation has improved in Nairobi slums between 2000 and 2012 although there are still some disparities with non-slum areas of the city and access rates are below national average. The proportion of households with piped water increased by 6 percentage points over 10 years while the proportion of households using public tap increased steeply. However, access to sanitation remains far below that of Nairobi residents, with less than a half slum residents reporting use of flush toilets in 2012.

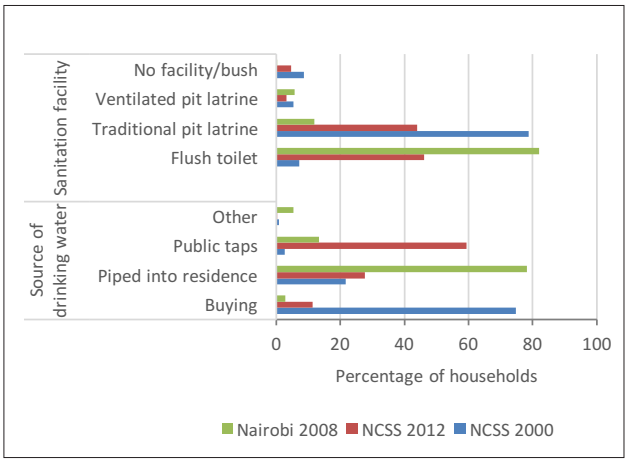

Figure 1. Percent distribution of households by amenities, NCSS 2000, 2012 and KDHS 2008-09.

Antenatal care and delivery

The proportion of women receiving Antenatal Care (ANC) is relatively high and comparable to the national average, but the central division is lagging behind with only 86.7% of pregnant women seeking care from a skilled professional (Figure 2).

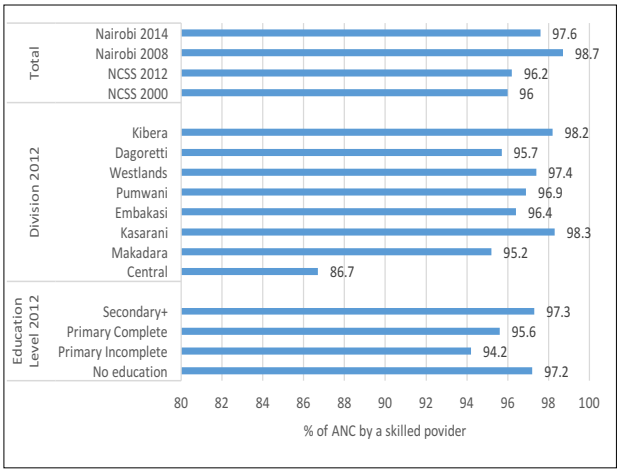

Figure 2. Antenatal care from a skilled provider, NCSS 2012, NCSS 2000 and KDHS 2008-09.

The proportion of mothers who initiated antenatal care in the first trimester significantly increased from 10% in 2000 to 17% in 2012 (Figure 3), but the majority of them initiated ANC during the second trimester. About a quarter of the women from Kibera Division have initiated the first ANC visit during the first trimester (24%) while the lowest early enrolment was observed in Kasarani Division (13%).

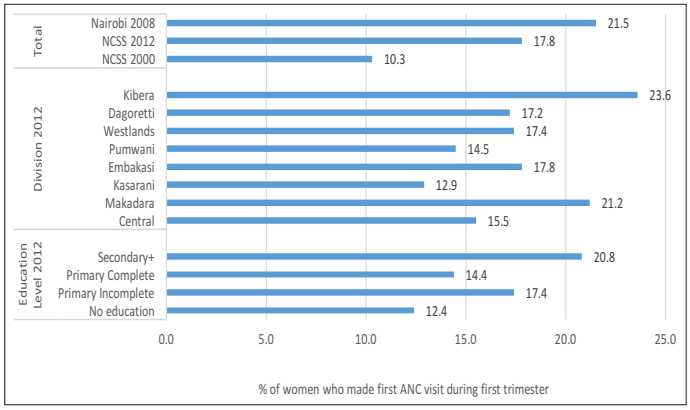

Figure 3. Timing of first ANC visit (% initiated during the first trimester), NCSS 2000, 2012, and KDHS 2008-09.

The frequency of ANC visits increased over time as the proportion of women who made at least four visits during pregnancy increased from 59% in 2000 to 66% in 2012 (Figure 4). Estimates from KDHS 2014 suggest that 73% of women had at least four ANC visits during their pregnancy[7]. The frequency of ANC visits increases with increasing education level, with women with at least a secondary level of education being the most likely to make at least four visits.

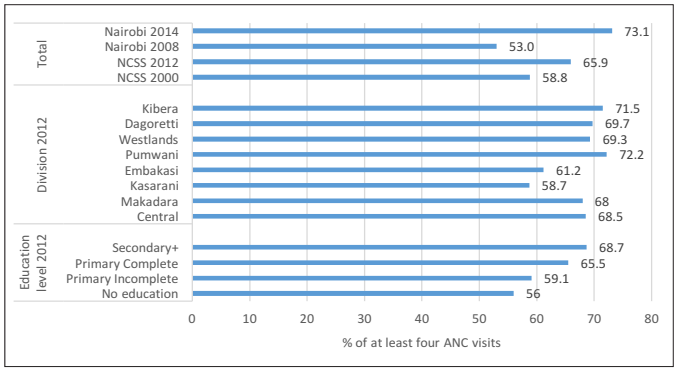

Figure 4. Frequency of ANC visits (% with four or more visits), NCSS 2000, 2012 and KDHS 2008-09, 2014.

Figure 5 shows assistance by skilled provider during delivery. Overall, delivery by skilled attendants has increased considerably between 2000 and 2012 (from 54% to 83%). Women's educaton is a key determinant of delivery assistance by medical personnel. Only 58% of women without formal education used services of s killed health provider during delivery compared to 90% for those with at least a secondary education.

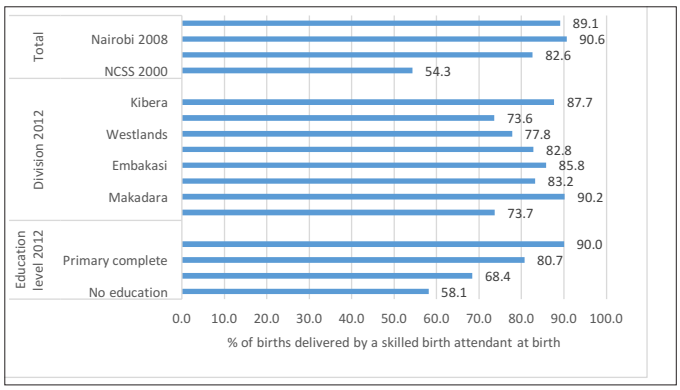

Figure 5. Skilled assistance during delivery, NCSS 2000, 2012 and KDHS 2008-09, 2014.

Childhood Immunization

Overall, full immunization coverage has increased among slum children aged 12-23 months, going from 45% in 2000 to 69% in 2012 (Figure 6). It is possible that areas such as slums which are not well covered during routine immunization benefited from outreach campaigns that occur during national immunization days for specific vaccines. Preliminary findings from the KDHS 2014 show that full immunization coverage reached 66% in Nairobi County, which is below the figures reported in the slum areas.

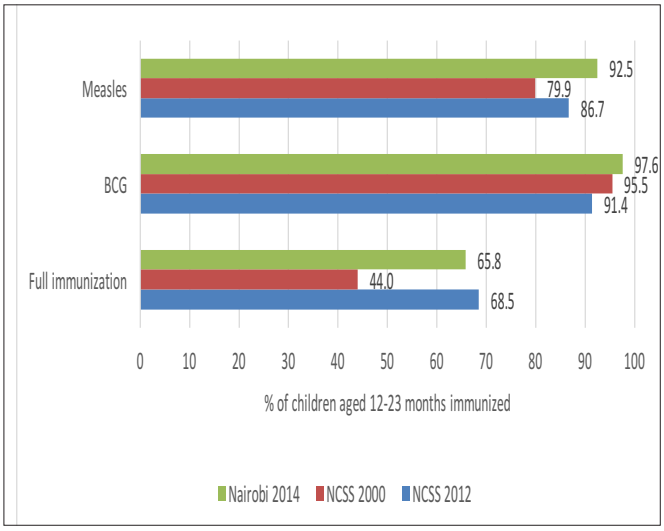

Figure 6. Percentage of children aged 12-23 months immunized by type of vaccine, NCSS 2000, 2012 and KDHS 2014.

However, the findings suggest that the recommended schedule for delivery of immunization services has not been effectively adhered and only 45% of children in 2012 had received all required vaccines by their first birthday compared to 41% in 2000 [8].

Data from Figure 7 show that Central Division has the lowest immunization rate (48%) while Kibera had the highest rate (83%). Full immunization was highest among women with at least a secondary level of education (71%).

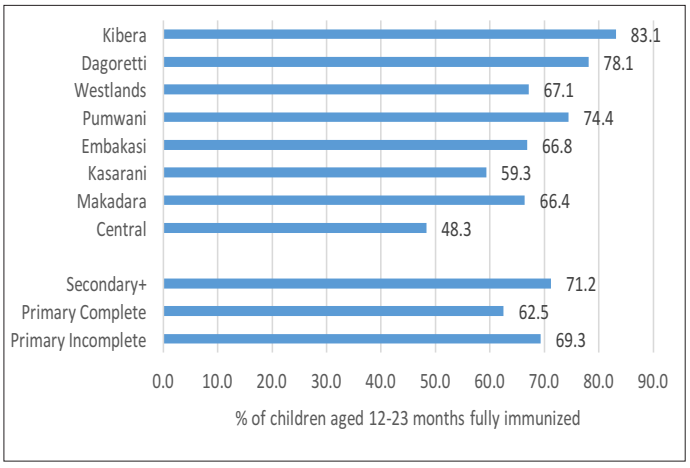

Figure 7. Percentage of children aged 12-23 months fully immunized, NCSS 2012.

Child morbidity

Figure 8 shows that the prevalence of diarrhea was 20% among under-3 children in 2012, a significant decrease as compared to 2000 (31%). Kasarani Division had the highest prevalence (34%) while Embakasi had the lowest. Embakasi Division had the highest proportion of children who received Oral Rehydration Salts (ORT) while Central Division had the lowest (40%). Mothers with no education were not using ORS.

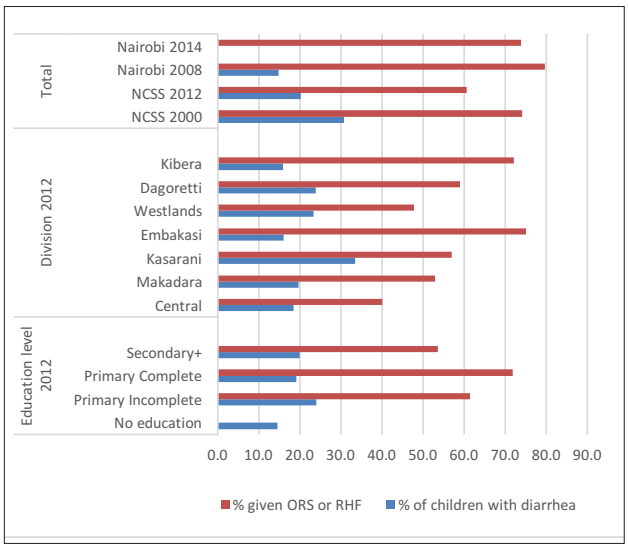

Figure 8. Prevalence of diarrhoea among under-3 children, NCSS 2000, 2012 and KDHS 2014.

Childhood mortality

Figure 9 shows that there is a general decline in childhood mortality in Nairobi slums between 2000 and 2012. For example, under-five mortality declined from 136 per 1,000 live births in 2000 to 80 per 1,000 live births in 2012. But this level is still higher than what was observed for Nairobi in 2014 [7]. Highest risk of an under-five death was observed in Central Division where generally the coverage for maternal and child health services was low.

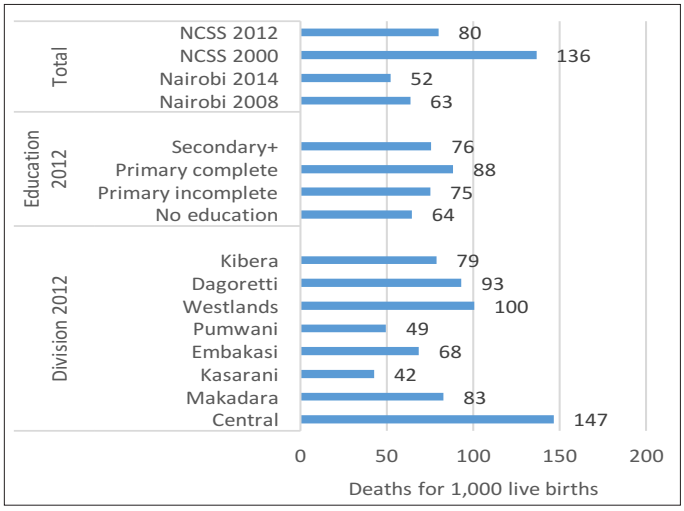

Figure 9. Under-5 mortality rates, NCSS 2000, 2012 and KDHS 2008/09, 2014.

Policy Implications and Recommendations

Overall, there is evidence showing that there is marked improvements in access to basic health, water and sanitation services among slum dwellers in Nairobi. However, these improvements are not uniform across the slums of the city. As the absolute number of slum dwellers will continue to grow, there is need for sustained investments to improve service delivery for achieving national development goals. Specifically:

- Access to water and sanitation remain a key concern for slum residents despite the general improvement.
- Despite the improvements in MCH care, opportunities are being missed to translate first contact in to delivering full package of antenatal and immunization services highlighting the importance of complementing supply side approaches with demand side interventions.
- Although deliveries by a trained professional were high in 2012, the child mortality rates are still high which raises a concern as quality in most of the health facilities in the slums has been found wanting.
- Immunization coverage for all recommended vaccines was low with only 44% of children fully immunized by their first birthday, falling very short of the recommended 85% coverage. There is need for rigorous community mobilization to educate parents/guardians on the benefits of full and on-schedule immunization of children. Further, there needs to devise ways to maximize coverage through more sustained outreach activities to bring the services to the communities to reduce the drop-out.
- Despite the reduction in the prevalence of common illnesses such as diarrhoea, a significant number of children are not appropriately treated with ORS. Effective education of the mothers about hygiene and creation of ORS corners in private facilities will help to widely disseminate the knowledge and improve household practices in handling diarrhoea among children. The entire community would benefit from education on promoting food hygiene and infant feeding.
- Although child survival improved, there are differences between slums due to underlying socio-economic differentials and access to basic services. Under-5 mortality is much higher in Central division which had relatively poor access to basic services among slum residents studied. These variations suggest that the gains made in child survival may not be sustainable unless targeted interventions are designed to reach the most vulnerable groups.

Conclusion

Despite improvements over the period 2000-2012, Nairobi slum dwellers are still lagging behind on a number of health indicators. Slum dwellers are productive members of the Kenyan society whose living conditions and health status should be given due consideration. In particular, the growing number of the urban poor suggests that their wellbeing will increasingly drive national development indicators such as the MDGs and the upcoming Sustainable Development Goals. It is therefore paramount that policy and program interventions are contextualized to specific situation. Surveys such as NCSS provide valuable information to inform strategies to improve services for the urban poor and assess the effectiveness of interventions not only in Nairobi but other urban centers in Kenya.

References

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Authors

- Dr. Donatien Beguy and Dr. Sam Oti (APHRC)
- Dr. G.V. Ramana and Dr. Jane Chuma (World Bank, Africa)