FACT SHEET
June 2012

African Population and
Health Research Center

Urban Health in Kenya

Key Findings: The 2000 Nairobi Cross-Sectional Slum Survey

In the year 2000, APHRC conducted the first Nairobi Cross-Sectional Slum Survey that examined health profiles of urban slum residents comparing them with those of rural residents in Kenya.

The 2000 "Population and Health Dynamics in Nairobi's Informal Settlements"[1] report showed that slum residents have poorer health and social outcomes than residents in more affluent neighborhoods, and perhaps surprisingly, than rural residents. Below we contrast the report's urban health findings with subsequent assessments including the recent 2008/09 Kenya Demographic Health Survey (KDHS).

Child Mortality

Under-5 (U5MR) and infant (IMR) mortality rates in Nairobi's slums were about 20 and 35 %, respectively, higher in the slum communities of Nairobi compared to rural Kenya. Evidence from the 2008/09 KDHS suggested that U5MR declined by 36% (from 115‰ to 74‰), while IMR dropped by 32% (from 77‰ to 52‰) between 2003 and 2008. More surprisingly, infant mortality in urban areas was 9% higher than that in rural areas, while IMR remained the same in urban areas between 2003 and 2008 whereas it declined by 27% in rural areas. In Korogocho and Viwandani slums in 2008, U5MR and IMR were estimated at 91‰ and 69‰, respectively.

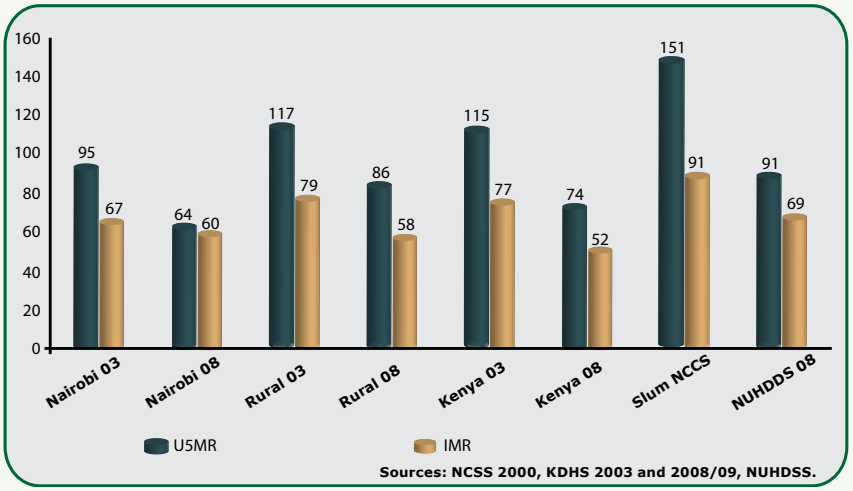


Figure 1. Under-5 and Infant Mortality Rates by Residence

[1]African Population and Health Research Center, Population and Health Dynamics in Nairobi's Informal Settlements: Report of the Nairobi Cross-sectional Slums Survey (NCSS) 2000, 2002, African Population and Health Research Center: Nairobi.

Childhood illnesses

Children living in slums were sicker than those living elsewhere in Kenya. However, they were less likely to access treatment when they are sick. Only 43% of those who had fever during the 2 weeks preceding the survey were taken to a health facility compared to 58% in the entire Nairobi. Evidence from the 2008/09 KDHS showed that the prevalence of fever at national level considerably decreased, passing from 41% in 2003 to 24% in 2008. The percentage of children taken to a health facility decreased in Nairobi while it remained almost the same in rural areas and for the whole Kenya.

Figure 2. Percent of children 0-35 with fever and percent of children with fever who were taken to a health facility

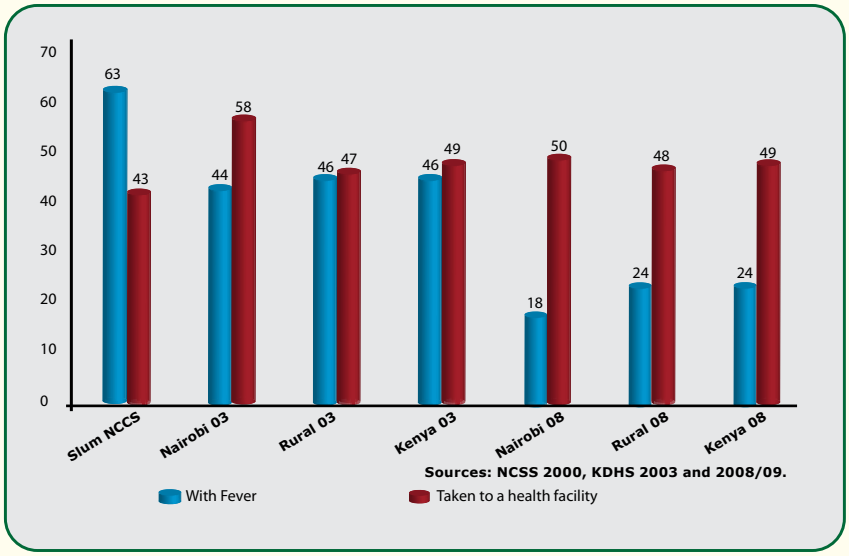
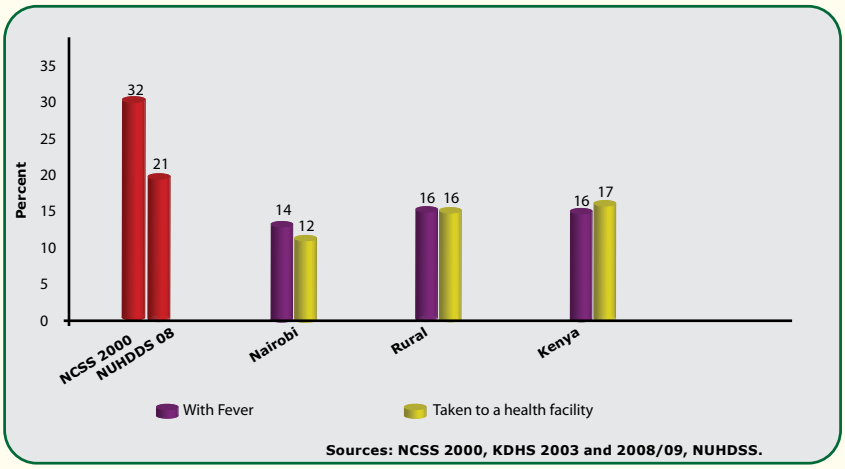


Figure 3. Percent of Children 0 – 35 months old with diarrhea



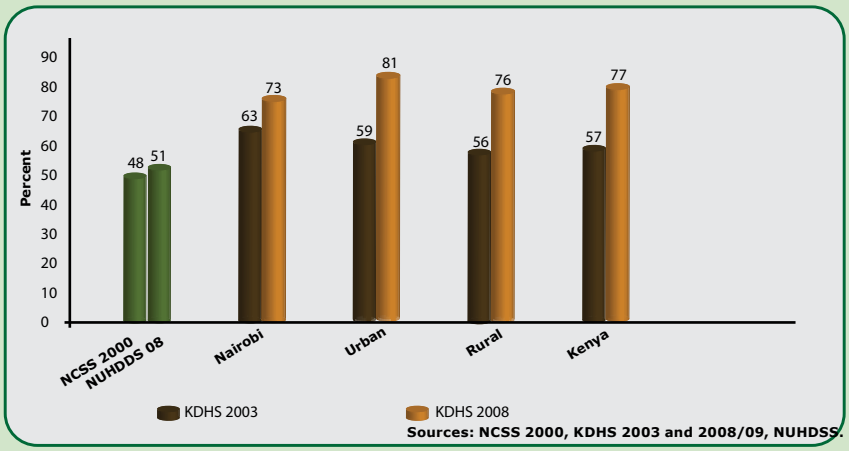
One in 3 children below 3 years of age in the slums had at least one episode of diarrhea in the two weeks preceding the survey compared to less than one in 5 children in other parts of Kenya including rural areas. Overall, the prevalence of diarrhea did not change much between 2003 and 2008. In Korogocho and Viwandani slums, it was estimated at 21% in 2008.

> *"Children living in slums were sicker than those living elsewhere in Kenya. However, they were less likely to access treatment when they are sick."*

Immunization coverage

Immunization coverage was also low among children living in slum areas than any other area, including rural areas. Between 2003 and 2008, vaccination coverage significantly increased but the pace was much lower in Nairobi than in other parts of the country. Vaccination coverage was estimated at 51% in Korogocho and Viwandani slums in 2008.

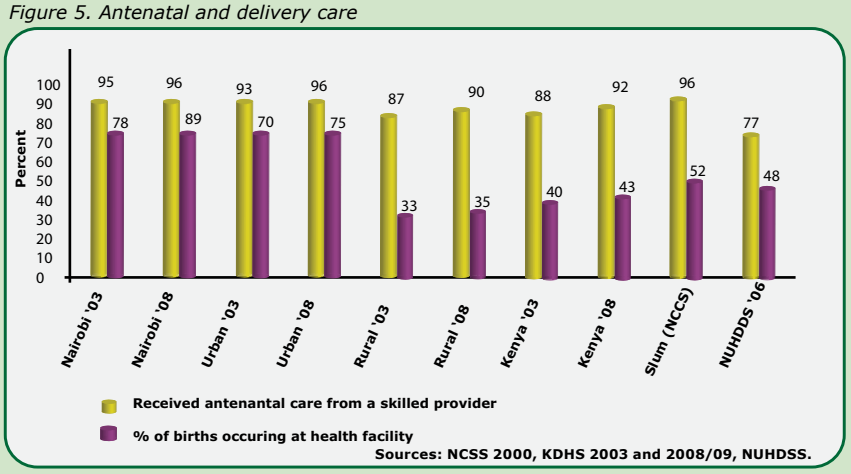
Figure 4. Percent of children 12-23 months who are fully vaccinated



Maternity care

About 50% of deliveries in the Nairobi slums take place in a health facility, compared to just over 33% in rural areas and about 78% in Nairobi as a whole. In 2008, 43% of births in Kenya as a whole, 89% in Nairobi and 35% in rural areas took place in a health facility. In Korogocho and Viwandani slums in 2006, 48% of births were delivered at a health facility.

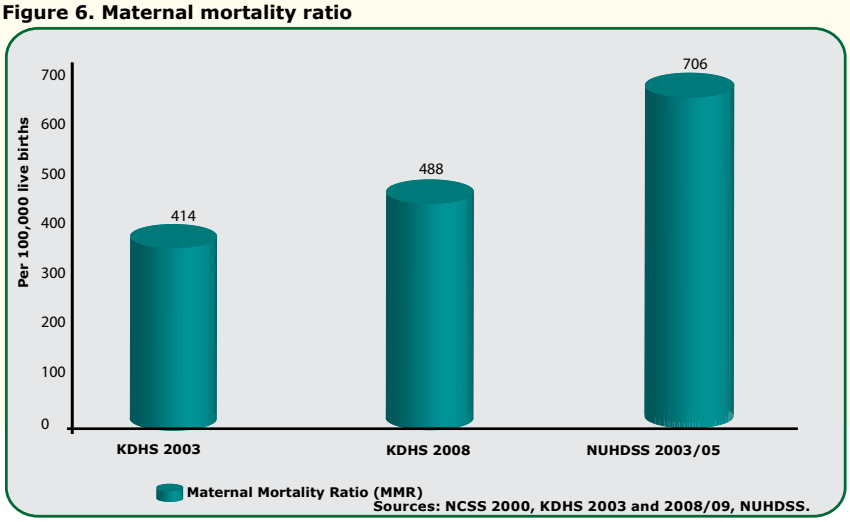
Figure 5. Antenatal and delivery care



Maternal mortality

Maternal mortality ratio (MMR) was estimated at 414 maternal deaths per 100,000 live births in 2003, and 488 in 2008. In Korogocho and Viwandani slums, MMR was estimated at 706 maternal deaths per 100,000 live births in 2003-05.

Figure 6. Maternal mortality ratio

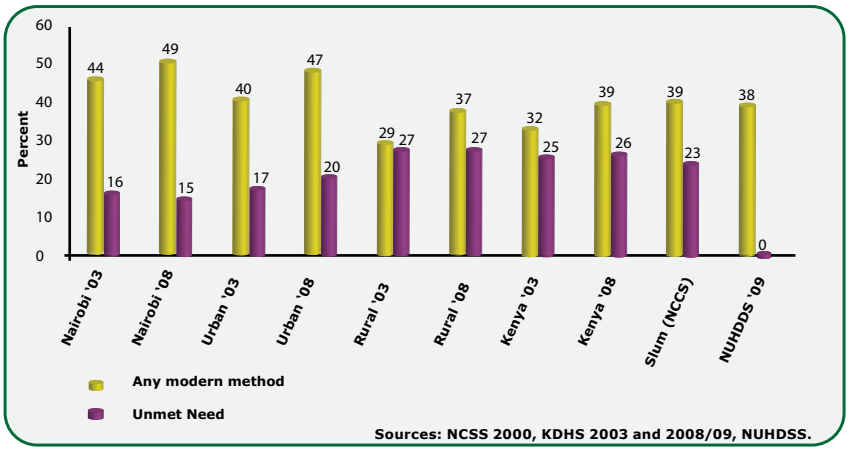


Contraceptive Use

Use of modern methods of contraception was estimated at 39% among married women in Nairobi slums in 2000, as compared to 32% in Kenya as a whole, 44% in Nairobi and 33% in rural areas, in 2003. Overall, the use of modern methods increased between 2003 and 2008. In Korogocho and Viwandani slums, it was estimated at 38% in 2009.

About 23% of women had an unmet need for contraception in Nairobi slums in 2000, as compared to 15% in Nairobi, 27% in rural Kenya and 25% in Kenya as a whole. No significant change was noted between 2003 and 2008, except a slight increase in urban Kenya.

Figure 7. Use of modern contraception and unmet for contraception



"Overall, the use of modern methods increased between 2003 and 2008."

The 2012 Nairobi Cross-Sectional Slum Survey

It is a little over a decade since the first Nairobi Cross-sectional Slum Survey was conducted and it is critical to take stock of the changes (or the lack thereof) since 2000. Partly due to the global push for the achievement of MDGs and partly due to enhanced accountability on the part of the Government of Kenya (GOK), the GOK and its development partners have given substantial attention and resources to improving health and economic outcomes in the past decade. For instance, the Ministry of Health in Kenya introduced a budget line for contraceptive commodities and made a policy shift on health service access whereby children under 5 years of age received free treatment at public health facilities. Other programs being implemented by the Government of Kenya and/or its development partners include the slum upgrading program, the cash transfer program to the elderly, the Free Primary Education program, the Output Based Approach Voucher scheme, among others.

While results from the recent 2008/09 Kenya Demographic Health Survey (KDHS) show that these programs are yielding positive results at national level, due to the limited coverage of slum residents in the sample, the report is unable to answer a number of questions critical to the health and livelihood of the urban poor [2]

In particular, have the urban poor benefited as much as other groups from the progresses registered at the national level or are they being left behind? And, are slum residents any better off (or worse off) today than they were 10 years ago? If so, in which areas are they doing better and in which areas have their situation worsened? Have inequities in reproductive health and demographic indicators between slum residents and other sub-groups in Kenya narrowed or widened?

Starting in June 2012, APHRC will conduct the 2nd Nairobi Cross-Sectional Slum Survey that will provide an updated demographic and health profile of the residents of Nairobi's informal settlements. The data collected will be relevant to understanding the local situation of the urban poor on population, family planning and reproductive health, maternal and child health, and other health-related issues. A total of 6,000 households, 5500 women aged 15-49 years, 2300 men aged 15-59 years and 2000 adolescents aged 12-24 years will be interviewed.

Conclusion

This survey is critical to the search for ways of reducing health inequities and improving health outcomes among vulnerable populations in Kenya and in other parts of sub-Saharan Africa. The information is essential to measuring progress towards the MDGs, in particular Goal 7, on the improvement of the lives of urban poor.

A comprehensive report will be officially launched in early 2013 and disseminated within Kenya. The report will also be widely shared across African countries similarly experiencing rapid urbanization and its attendant problems.

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[2]Division, U.P., World Population prospects: The 2008 Revision Population Database, 2009.