ACCESS TO HEALTHCARE FOR THE URBAN POOR IN NAIROBI, KENYA

Harnessing the Role of the Private Sector in Informal Settlements and a Human Rights-Based Approach to Health Policy

Pauline Bakibinga and Elizabeth Bakibinga-Gaswaga

Introduction

The world is experiencing rapid urbanization, and nowhere in the world is rapid urbanization as challenging as in sub-Saharan Africa (SSA) (UNFPA 2007). This region has the highest urban growth rate in the world of up to 4% annually, and the urban population is expected to grow to 60% by 2050 from 37% in 2011, with the majority of the urban residents living in informal settlements (UN-Habitat 2003a, 2003b, 2010). The rapid growth in urban population is driven by rural–urban migration, further exacerbated by internal displacement of people and the effects of climate change. Rural–urban migration often results in lifestyle changes associated with a shift to a high burden of chronic diseases such as cancers, cardiovascular diseases, chronic respiratory diseases and diabetes. Rapidly urbanizing populations have pressing healthcare needs, and thus the health systems ought to be prepared to act swiftly to support and sustain the needs of such populations (Oliver 2014). However, the health systems in most countries in the SSA region have not been quickly adapted to match the population health needs. Most health systems are still stuck at providing institutionalized emergency and curative services for infectious diseases such as malaria, tuberculosis and HIV, which are still highly prevalent in informal settlements. Having a double burden of infectious and non-communicable diseases requires a government response tailored to addressing both.

Drawing on the authors’ experiences as well as the existing literature and using Nairobi, Kenya as an example of an African city with a fast growing urban poor population, this chapter provides an overview of the current health status of the urban poor, access to and utilization of health services, challenges and governance of health services, and how partnership with the private sector and a human rights-based approach to policy and programming would strengthen health service delivery to the urban poor.

Health Status, Access and Utilization of Health Services by the Urban Poor in Nairobi

Urban informal settlements in Kenya have the highest levels of maternal and child mortality: 706/100,000 and 53/1,000 live births respectively (APHRC 2014; UN-Habitat 2003a, 2003b;
The maternal mortality is nearly twice as high as Kenya’s national average of 362/100,000 live births, while child mortality was equivalent to the national average of 52/1,000 livebirths (KNBS 2015) (see Table 9.1). The three broad groups of diseases causing death among residents of informal settlements were: Group 1: communicable diseases, maternal and nutritional causes, accounting for 71% of deaths; Group 2: non-communicable diseases (10%); and Group 3: injuries, accounting for 13% (Kyobutungi et al. 2008).

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Nairobi slums</th>
<th>Nairobi city</th>
<th>Kenya</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 12–23 months fully vaccinated (%)</td>
<td>51</td>
<td>74.9</td>
<td>79</td>
</tr>
<tr>
<td>Delivery with skilled birth attendant (%)</td>
<td>75</td>
<td>89.1</td>
<td>62</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>59</td>
<td>55</td>
<td>39</td>
</tr>
<tr>
<td>Under-five mortality rate (per 1,000 live births)</td>
<td>79</td>
<td>72</td>
<td>52</td>
</tr>
<tr>
<td>HIV prevalence (males and females)</td>
<td>11.5</td>
<td>9.2</td>
<td>5.6</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (%)</td>
<td>53</td>
<td>62.6</td>
<td>42.6</td>
</tr>
<tr>
<td>Unmet need for contraception (%)</td>
<td>31</td>
<td>11.1</td>
<td>18</td>
</tr>
<tr>
<td>Attended at least four ante-natal clinic visits</td>
<td>54</td>
<td>73.1</td>
<td>58</td>
</tr>
</tbody>
</table>

Sources: Nairobi Urban Health and Demographic Surveillance Survey (NUHDSS) and other APHRC data; KNBS (2015); Kenya AIDS Indicator Survey (KAIS) 2012.

Ziraba, Madise et al. 2009). The maternal mortality is nearly twice as high as Kenya’s national average of 362/100,000 live births, while child mortality was equivalent to the national average of 52/1,000 livebirths (KNBS 2015) (see Table 9.1). The three broad groups of diseases causing death among residents of informal settlements were: Group 1: communicable diseases, maternal and nutritional causes, accounting for 71% of deaths; Group 2: non-communicable diseases (10%); and Group 3: injuries, accounting for 13% (Kyobutungi et al. 2008).

Figure 9.1 A private health facility in a Nairobi slum.
Source: Photo by Mirriam Okwalo.
Abject poverty and limited access to essential preventive and curative services for women and their children are the major underlying factors contributing to the high mortality in the informal settlements (APHRC 2002, 2014). Informal settlements are generally characterized by poor environmental and sanitation conditions, poor access to basic amenities and social and health services, and poor livelihood opportunities (APHRC 2002; Zulu et al. 2002). Whereas health facility births have increased significantly from 52% in 2000 to 81% in 2012 (APHRC 2014), the quality of care available in the facilities still remains poor (APHRC 2014; Fotso et al. 2009). In one study, where 70% of mothers were reported to have delivered in a health facility, only 40% delivered in an appropriate health facility with trained staff and equipment to handle basic emergency obstetric and neonatal complications (Fotso et al. 2009; Ziraba, Mills et al. 2009) (see Figures 9.1 and 9.2). Nearly one-fifth (18%) of all births still happen under the supervision of untrained non-professional care providers such as traditional birth attendants, relatives and other unskilled persons.

While there are individual and community level barriers to accessing and using maternity and child healthcare services among the urban poor, the poor state of both maternal and child care services in this setting substantially contributes to the high mortality observed in Nairobi (Emina et al. 2011). Although informal settlements are within the city, not far from major hospitals providing

Figure 9.2  A health facility in Viwandani slum in Nairobi.
Source: Photo by Mirriam Okwalo.
specialized services to the entire country, residents of informal settlements are often unable to access quality services because they cannot afford the high treatment costs, health facilities within the informal settlements only open during busy work schedules, residents also fear travelling at night owing to insecurity in the informal settlements, and few free public health facilities are located within their vicinity; poor attitudes of healthcare providers in public facilities were also cited as a barrier to accessing free services (Bakibinga, Ziraba et al. 2016; Emina et al. 2011; Essendi et al. 2011; Fotso and Mukiira 2012).

**Status of Healthcare in Nairobi City County**

**Management of Health Service Delivery**

The health service delivery structure is divided into four governance and management tiers: national, county, sub-county and community levels. Nairobi county health services are governed by both the ministry of health and the ministry of local government through the city council coordinated by the Nairobi health management board. The city council of Nairobi through the department of public health is responsible for the overall coordination and management of public health services in the city. The county health management teams carry out strategic and operational planning, coordination and implementation of primary health services in the district. All hospitals are managed by hospital management teams which comprise departmental heads. Health facility management committees oversee the running of primary healthcare facilities, and community health committees coordinate and implement community health services through the community units.

**Facilities and Health Infrastructure**

Health services are provided through the public, private and faith-based organizations (FBO), with the private and FBO sectors projected to contribute approximately 60% of health services in Nairobi county. As of 2013 (NCHIWG 2013), Nairobi county had approximately 503 registered health facilities, of which the majority (257) were privately owned, followed by 132 owned by an FBO/NGO and 114 government owned public facilities. These facilities provide a range of curative and preventive services including tuberculosis treatment, HIV/AIDS comprehensive care, dental care, and maternal and child health services. Nairobi has four county and sub-county level referral hospitals offering services that range from general outpatient services to curative specialized care services.

**Human Resources for Health**

Nairobi continues to face enormous challenges in human resources for health. In 2013, Nairobi was reported to have a total of 2,404 health workers serving in both the public and the city council health facilities (NCHIWG 2013). The few health workers in Nairobi are faced with many occupational health and safety hazards exacerbated by the lack of clear policies, management programmes and designated safety resource persons at facilities.

**Healthcare Financing**

Government funding is expected to be the main source of funding but does not adequately finance health services in the county. Other sources of health financing, including support from partners through bilateral agreements or direct support to annual operational plans, individual out-of-pocket payments and health and medical insurance, tend to be the main source of health financing.
Access to Healthcare for the Urban Poor in Nairobi

(NCHIWG 2013). Even with public health insurance introduced since 1966, only 20% of Kenyans have accessed some form of medical coverage. One-quarter of total spending on healthcare comes from out-of-pocket payments. Health insurance is expected to alleviate out-of-pocket expenditures and reduce outrageous payments (Escobar et al. 2010). However, enrolment in health insurance schemes in urban informal settlements in Nairobi remains low. Only 11% of the population are covered by the National Hospital Insurance Fund (NHIF) and 4% covered by private insurance schemes (Futures Group 2016). By 2012, 89% of respondents in urban informal settlements were not covered by any type of health insurance, and only 10% and 0.8% were covered by NHIF and private insurance schemes, respectively (Kimani et al. 2012). Although the Kenyan government has committed itself to free maternity care and universal health coverage, the meagre government allocations coupled with low enrolment in health insurance schemes remain major impediments to universal health coverage. The impact of the World Bank Group’s Health in Africa initiative aiming to provide insurance cover for 125,000 Kenyans in 23,500 families across 47 counties to improve medical cover to the poorest is yet to be seen.

Challenges of Health Service Provision in Nairobi

Health service provision in Nairobi is riddled with numerous governance and management, infrastructure, health management and health financing challenges. Some of the challenges identified include poor referral systems, inadequate skilled personnel in health leadership and management, multiple management levels complicating coordination of health programmes, poor medical records due to a slow transition from manual to electronic medical records hindering accessibility of data in real time for decision making, poor coordination of development partners leading to duplication of services, and few and inaccessible health facilities not responding to the population needs in informal settlements worsened by laws restricting the upgrading of the facilities. Health infrastructure in most health facilities is dilapidated and unfit for storage of drugs and medical supplies. This is coupled with poor medical waste management practices. A large number of undocumented immigrants present with numerous health problems, and yet they are not included in the annual budgeting for procurement of essential medicines and medical supplies, thus leading to a chronic shortage of medicines and supplies in the health facilities. This situation is made worse by lack of harmonized coordination and supervision of health services provided by various stakeholders (APHRC 2014). In such settings, the urban poor are left with no option but to take difficult decisions on where to seek health services to fend for themselves and thus vote with their feet to seek care from the nearest and most affordable private health facilities, and sometimes this includes visiting untrained providers such as traditional healers. A study on health seeking behaviour by mothers of children under five years of age in Nairobi informal settlements revealed that shops are used as the first source of health care and, when the care moves out of the home, private health facilities are used more compared to public health facilities, while some mothers consult traditional healers (Amuyunzu-Nyamongo and Nyamongo 2006).

The Role of the Private Health Sector in Nairobi

Private health facilities are the leading providers of health services in informal settlements across cities in SSA (Ekiyapa 2012; IFC 2016). Several studies conducted in the informal settlements of Nairobi attest to this finding (Ekiyapa 2012; Essendi et al. 2011; Fotso and Mukiira 2012; Kyobutungi et al. 2008). Owing to the informal nature of these settlements, nearly no public health facilities are established for this population. However, few public health facilities exist, especially in the surrounding formal settlements (Ekiyapa 2012). The majority of healthcare therein is provided by a vibrant private
sector, but the challenge with the private providers in the informal settlements is the questionable quality and limited range of services provided (Essendi et al. 2011; Fotso et al. 2009). Supporting the private healthcare facilities in the informal settlements in Nairobi would therefore be needed to improve the quality of healthcare in these settlements. However, the linkages between the healthcare delivery system in the informal settlements and formal government health systems are weak. Most national programmes in Kenya, such as the free maternity care which was rolled out in 2013, were only made available at public health facilities and have therefore not been accessed by informal settlements. Furthermore, many private health facilities in the informal settlements are not regulated: most of them have no formal registration and thus do not benefit from free medical supplies, equipment and supervision provided by the county governments. Healthcare workers in this sector rarely benefit from in-service training to update their skills to offer essential services such as basic and comprehensive emergency and obstetric care, family planning and management of common childhood illnesses.

In addition, essential services such as vaccination and family planning that are usually provided at public facilities at no cost are largely inaccessible to residents of informal settlements because they are provided at a cost by private health facilities (APHRC 2002, 2014). While most informal settlements are within 10 kilometres of major healthcare facilities in Nairobi, services are not accessible. For example, many women still deliver at home with the help of traditional birth attendants or relatives, or at substandard health facilities without skilled birth attendance (APHRC 2014). Despite these challenges women continue to seek care from the private health facilities and report satisfaction with the services, particularly because of ease of access and more friendly healthcare staff in private clinics compared to those in the public healthcare facilities (Bakibinga, Kamande, and Kyobutungi 2016).

Current Interventions to Improve Service Delivery for the Urban Poor

Fuelled by the global agenda for the achievement of sustainable development (SDGs), the government and its partners have implemented some programmes targeted at improving the wellbeing of the urban poor (Bakibinga et al. 2014). In the last 15 years, attention and resources invested in supporting informal settlement programs such as informal settlement upgrading and reproductive health voucher schemes among others have been increasing (Butala et al. 2010; Lilford et al. 2015; Watt et al. 2015). One strategy used to improve primary healthcare services in the informal settlements is the community health strategy. The strategy established community health volunteers (CHVs) as the first line of contact with the health system and linked them to primary health facilities under supervision of community health assistants. This was partly in response to a shortage of healthcare workers, necessitating the use of CHVs as an alternative health workforce. The contribution of CHVs to primary healthcare is gaining recognition in Kenya as elsewhere globally (Haines et al. 2007). Their role is particularly appreciated among the urban poor who have not benefited from national programmes, partly owing to their informal nature. Various innovative programs involving CHVs have also been implemented in the informal settlements in order to address some of the barriers to accessing health services. One such programme is the health systems strengthening service delivery model referred to as the Partnership for Maternal, Newborn and Child Health (PAMANECH) (Bakibinga et al. 2014) (see Figure 9.3). Focusing on public–private partnerships for service delivery at the primary level, the project aimed at improving health service delivery for maternal, newborn and child health (MNCH) through several components. These initiatives included establishing a network of health facilities to deliver community-based services, infrastructural upgrade of selected private health providers, building capacity of healthcare workers (see Figures 9.4 to 9.7 for these first three), improving leadership and governance, strengthening the health management information system, and establishing an emergency referral system. This has had a great impact on service delivery for marginalized communities (Bakibinga, Ziraba et al. 2016).
Figure 9.3  The Partnership for Maternal, Newborn and Child Health (PAMANECH) service delivery model.  

Figure 9.4  A group of community health volunteers in the Viwandani and Korogocho slums in Nairobi, after a training session on maternal, newborn and child health.  
*Source:* Photo by Jane Osindo.
Figure 9.5  Infrastructure upgrade of a maternity unit in Viwandani slum in Nairobi.
Source: Photo by Eva Kamande.

Figure 9.6  A health worker training session for providers working in the slums of Nairobi.
Source: Photo by Jane Osindo.
Key achievements from the PAMANECH implementation include: better functionality of upgraded healthcare facilities in terms of variety and quality of services; official recognition by regulatory authorities (two facilities, previously unregistered and unrecognized, were licensed by the government); all six facilities supported by the project becoming eligible for National Hospital Insurance Fund (NHIF) reimbursements covering out- and in-patient and maternity services, which led to an increase in healthcare utilization for essential maternal and child health services; and stronger relationships being established between the public and private sector facilities, with the private health facilities benefiting more from in-service training and access to publicly supplied health commodities. Lastly, a strong network and partnership between the healthcare providers and CHVs was cultivated through this project. These investments have seen improvements in livelihoods, increased health facility deliveries, an increased number of children fully immunized, a greater contraceptive prevalence among married women, and decreased child mortality (APHRC 2014).

Critical unanswered questions still exist for the success of this partnership with private healthcare providers. The main challenge is how these successes can be sustained beyond the duration of the donor funding. Some persisting needs such as strengthening health providers’ leadership skills and increasing the enrolment of the urban poor into existing medical insurance schemes still remain a challenge. Data collection and collation remain a challenge among private health providers. A high turnover of clinical staff trained in basic MNCH packages continues to be a challenge, because the staff tend to seek better remuneration packages elsewhere as the managers of the facilities supported
are not providing adequate welfare packages. It was also observed that the community members continue to expect free health services from the upgraded health facilities. These challenges need to be taken into consideration for a successful execution of a private partnership in health for the urban poor as a lasting solution. Given the lack of local resources, weak state support and high donor dependency (Amuyunzu-Nyamongo et al. 2007; PSP4H 2014), reliance on this approach alone will not be sustainable. There is a need to advocate for innovative policy and programming driven by a human rights approach.

A Rights Approach to Health Systems Strengthening

The role of human rights in advancing population health is an issue that has gained momentum internationally. This is because a human rights-based approach to health reduces inequalities. In the Millennium Development Goals of 2000, the UN made a commitment to advance population health through three health specific goals. Emphasis was placed on the reduction of child mortality, improvement of maternal health and combating HIV/AIDS, malaria and other diseases. Upon realization that member states were likely to miss the targets set for universal access to reproductive health services and reduction of maternal mortality by 75% and the under-five mortality by two-thirds, the WHO and the Office of the High Commissioner for Human Rights developed guidance on a human rights-based approach (HRBA) (UNDG-HRWG 2003). It was anticipated that, with HRBA, every person’s right to the enjoyment of the highest attainable standard of health would be respected and protected, and also protected by international law. More recently the global community has adopted the SDG Agenda 2030 (see Table 9.2), consisting of interdependent, crosscutting and integrated goals. One distinctive feature in the SDGs is the inclusion of a goal that emphasizes the role of legal frameworks in enabling development. During the evaluation of the MDGs, it became clear that lack of a goal that focused on enabling the delivery of the other goals had negatively impacted on the success of the millennium development framework. The SDGs therefore include the rule of law as SDG 16, which emphasized the role of policy, legislation and regulatory frameworks in enabling the attainment of the targets set and facilitating the monitoring and evaluation function (UN 2015). At this point, it is critical to note that promoting the HRBA in building resilient and effective health

<table>
<thead>
<tr>
<th>Goal</th>
<th>Targets</th>
</tr>
</thead>
</table>
| SDG 2: Achieve improved nutrition | 2.1 By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round.  
2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons. |
| SDG 5: Achieve gender equality and empower all women and girls | 5.1 End all forms of discrimination against all women and girls everywhere.  
5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.  
5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.  
5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences. |
SDG 6: Ensure availability and sustainable management of water and sanitation for all

| **SDG 6** | **By 2030,** achieve universal and equitable access to safe and affordable drinking water for all. |
| **By 2030,** achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations. |

SDG 10: Reduce inequality within and among countries

| **SDG 10** | **By 2030,** empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status. |
| **By 2030,** ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard. |
| **By 2030,** adopt policies, especially fiscal, wage and social protection policies, and progressively achieve greater equality. |

SDG 11: Make cities and human settlements inclusive, safe, resilient and sustainable

| **SDG 11** | **By 2030,** ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums. |
| **By 2030,** provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons. |
| **By 2030,** enhance inclusive and sustainable urbanization and capacity for participatory, integrated and sustainable human settlement planning and management in all countries. |
| **By 2030,** significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations. |
| **By 2030,** reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management. |
| **By 2030,** provide universal access to safe, inclusive and accessible green and public spaces, in particular for women and children, older persons and persons with disabilities. |
| **Support positive economic, social and environmental links between urban, peri-urban and rural areas by strengthening national and regional development planning.** |

SDG 13: Take urgent action to combat climate change and its impacts

| **SDG 13** | **Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries.** |
| **Integrate climate change measures into national policies, strategies and planning.** |
| **Improve education, awareness-raising and human and institutional capacity on climate change mitigation, adaptation, impact reduction and early warning.** |

---

systems requires a review of the policy and legal framework in the selected political sphere, in this case Kenya. Thereafter, it is critical to review the state of affairs in healthcare access in the informal settlements and the interventions that have been put in place to address shortcomings.

The Kenya Health Policy 2012–2030 is premised in the constitutional provisions that guarantee the right to health. The policy is expected to comprehensively address issues of access to healthcare services for vulnerable and marginalized groups, including the urban poor. The policy was developed to promote the HRBA to healthcare delivery by striving to base the policy’s design, implementation, monitoring and evaluation on the principles and norms of human rights. It ensures equity in
the distribution of health services, a people-centred approach to healthcare, a participatory approach to intervention delivery and a multi-sectoral approach to realizing health goals (Maalim et al. 2014). However, the policy fails to give adequate attention to the specific health needs and aspirations of vulnerable groups. It does not demonstrate specific contexts in which a particular vulnerable group might require an accelerated or specialized treatment, nor does it address particular populations of high vulnerability.

The approach to state interventions, including at the time of county or national strategic planning, requires consideration of three types of state obligations. The state is required to ensure respect by not interfering directly or indirectly with the enjoyment of the right to health, such as refraining from limiting access to healthcare services or marketing unsafe drugs. Secondly, the state should protect by preventing third parties from interfering with the right to health, for example ensuring that private companies provide safe environmental conditions for their employees and surrounding communities. Lastly, the state should fulfil its obligations by adopting appropriate legislative, administrative, budgetary, judicial and other measures to fully realize the right to health.

There is a need to understand and take into account the structure of governance and the foundation of the modern state in Kenya, right from the dawn of colonialism to independence in 1963. The political history of Kenya is characterized by power asymmetries, which has substantially affected resource allocation and service delivery by excluding vulnerable populations in health system planning. These inequalities have to be addressed. At the 68th World Health Assembly in May 2015, non-state actors such as civil society organizations, international non-governmental organizations and patients’ groups expressed concerns about the impact of social-structural factors in countries. Emphasis was placed on inaccessible political power and decision-making structures in the economic, financial, social-welfare and health policy-making. These were identified as drivers of inequalities, discriminatory practices and unjust power relationships within the health systems. Health equity can only become a reality when policy is focused on ensuring the fair distribution of service delivery that meets people’s needs, rather than healthcare distributed according to social privilege.

The health sector in Nairobi cannot be understood by mere identification of components, products, ensembles and connections. There is a need to understand the representation and communication of information in the systems, predicting component functions from process sequence and institutional framework or structure. This complexity has been acknowledged through the sector-wide programmatic approach taken in some countries. There is a lot to learn from the Kenya Health sector-wide approach code of conduct between Kenya’s ministry of health, development partners and implementing partners. The code of conduct provides for respect for human rights, equity, democratic principles and good governance as underlying principles of the partnership to deliver health in a sector-wide manner. It emphasizes the commitment to ensure the mainstreaming of poverty reduction, equity, gender, governance, anti-corruption measures, HIV/AIDS and environmental issues in policies, planning, impact assessment, service delivery and evaluation. The code also requires that the needs of other marginalized groups of society such as the urban poor, the displaced and the disabled be specifically addressed.

More effort must be placed on promoting universal health access, emphasizing stakeholder engagement, and paying heed to glocalization to help in localizing the global agenda to the lowest level of government. Climate change brings with it increased numbers of deaths and injuries and other challenges to public health. This is due to the increased intensity and/or frequency of storms and flooding as a result of inadequacies in drainage and flood protection stemming from poor planning and infrastructure in urban centres in Africa and other parts of the world (Satterthwaite 2007). For any city, including Nairobi, the scale of the risk from these extreme weather events is much influenced by the quality of housing and infrastructure, including the adequacy of solid-waste
management or drain maintenance, and garbage and plant control in that city. Urban planning and land-use management have successfully ensured risk reduction within urban construction and expansion, and the level of preparedness among the city’s population and key emergency services (Douglas et al. 2008). Nairobi county government will be expected to do more to address the issues affecting the informal settlements (Douglas et al. 2008). Development partners and other actors will be expected and should be encouraged to step in and mitigate the limited state presence in informal settlements by providing health services in areas much more impacted upon by climate change.

A well-designed health service programme will contain a component of monitoring and evaluation in measurement to assess the burden of not only various health issues but also HRBA to enable better planning of health interventions to marginalized groups.

**Conclusion**

The right to health is explicitly stated in national and international declarations, and the SDGs are clear on leaving no one behind. Although Nairobi county and Kenya as a whole have made significant strides in improving health access to the urban poor population, there is a lot more that can be done. Measures have to be taken to address the challenges that people living in informal settlements face in Nairobi. Lack of access to major healthcare facilities due to cost, restricted opening hours, insecurity at night, limited availability of public health facilities and perceived poor client orientation of service providers, in particular, in public facilities in these neighbourhoods still need to be addressed. The Kenya state and its constituent county governments have a responsibility and mandate not only to coordinate and supervise but also to provide services, including but not limited to health. Since delivery of adequate health services transcends the health sector, inter-sectoral strategies informed by a rights-based approach need to be harnessed for better service delivery to the urban poor.

**References**


