DEBUNKING THE PUBLIC HEALTH PUZZLE

AN ASSESSMENT OF THE FACTORS THAT HINDER ENJOYMENT OF HEALTH AS A PUBLIC GOOD IN URBAN INFORMAL SETTLEMENTS

FINAL REPORT

Nairobi, February 2020

CONTENTS

ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ARV	Antiretroviral
CHWs	Community Health Workers
CoK	Constitution of Kenya
FBOs	Faith Based Organizations
FGDs	Focus Group Discussions
GoK	Government of Kenya
HRBA	Human Rights-Based Approach
HRH	Human Resource for Health
HSSF	Health Sector Services Fund
KEMSA	Kenya Medical Supplies Authority
KES	Kenya Shillings
KHSSP	Kenya Health Sector Strategic and Investment Plan
KIIs	Key Informant Interviews
KRA	Kenya Revenue Authority
MES	Managed Equipment Services project
NGO	Non-Governmental Organization
NHIF	National Hospital Insurance Fund
NSAs	Non-State Actors
PRISMA	Preferred Reporting Items for Systematic review and Meta-Analysis
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage

ABSTRACT

This report provides an assessment of the factors that hinder enjoyment of health as a public good within urban informal settlements. It provides insights into the policy, structural and administrative gaps within public health; while determining the quality and scale of private healthcare provision against public health care in Kibera, Korogocho and Kisauni informal settlements. The report further highlights the elements that propagate private healthcare provision in informal settlements and presents recommendations on the actions the government should take to ensure inclusivity and success of Universal Health Care Agenda particularly for the marginalized groups.

The growth of urban slums has been attributed to various factors including rapid rural-to-urban migration, high unemployment, poverty, and poor planning with the resultant effect being strain on physical infrastructure and social services. Access to quality Healthcare services in informal settlements in Kenya remains a challenge given its level of availability, accessibility, affordability, and acceptability by informal settlement dwellers. The study findings reveal that within Kibera, Korogocho and Kisauni, health care services are accessible through four broad categories i.e. Public facilities; Private facilities; Charity/Mission facilities and Non-governmental facilities with the key motivators for slum dwellers in accessing preferred healthcare options being accessibility and affordability. Public healthcare facilities are inaccessible to many informal settlement dwellers, given their limited number and proximity to the informal settlements. Kibera, the largest informal settlement in Kenya whose population as documented in the 2019 Kenya Population and Housing Census is 185,777[1] has 70 registered health facilities which implies a health provider to patient ratio of 1: 2,654 for the majority level 2 facilities. Of the 70 registered health facilities, 3 are run by the Ministry of Health.

The government's National Health Insurance Fund whose intention is to enable all Kenyans to access quality and affordable health services, has failed to adequately address the needs of vulnerable populations owing to service provider capitation issues and client's financial constraints. These factors have propagated the rise of private healthcare facilities in informal settlements, which are commonly unregulated; offering poor quality services and are exploitative; as most are run with a profit motivation that takes advantage of the micro-economy culture in informal settlements. The access to healthcare gap within informal settlements has however been bridged by the existence of Charity/ Mission and NGO run healthcare

[1] https://www.knbs.or.ke/?wpdmpro=2019-kenya-population-and-housing-census-volume-i-population-by-county-and-sub-county

facilities that provide offer comprehensive basic healthcare and maternity services integrated with the management of chronic diseases like HIV, targeting of the most vulnerable populations. Despite the presence of such facilities, the swelling population is still underserved. Other barriers to access to public healthcare services by informal settlement dwellers include the under-financing of Kenya's health sector coupled with the perceived unfriendliness to informal settlement dwellers illustrated by long waiting time, unaffordability, poor quality of care, distance, and attitude of health workers. As such informal settlement residents tend to view Health as a perceived and not actual right.

Despite the above, accelerators of access to healthcare are existent such as technological innovations e.g. M-Tiba which allows one to save, send, and spend funds specifically for medical treatment. The government's commitment to Universal Health Coverage has also provided a basis to accelerate access to health services despite its slow roll out, and similarly the integration of Community Health Services to the Health Referral System has also made a significant contribution to enabling access to health services for informal settlement dwellers.

The study thus points to the fact that enjoyment of health care as a public good remains a mirage to informal settlement dwellers given the numerous factors hampering access and affordability. These factors have been compounded by the continued absence of a supportive framework for citizens to engage and participate in priority setting during Health sector planning processes. Deliberate strategies must therefore be put in place to activate citizens engagement in tracking policy implementation thus ensure policy objectives are realised and that affordable, quality healthcare is readily accessible to all citizens including typically marginalized groups such as informal settlement dwellers. This realization forms a good basis for structured engagement with the government in the push for access to health as a public good for residents of informal settlements, specifically on lobbying the government to focus its energies on getting policy implementation right in relation to Health Financing. This would call for a review of the NHIF model to ensure provisions are made for social protection of the most vulnerable in the society as opposed to a premium-based regular contribution approach. An alternative approach can be adopted, that strives to pool resources thus cushion vulnerable populations whilst improving payment mechanisms to better control both cost and quality of health services.

On the health financing gap, the study recommends deliberate lobby efforts aimed at pushing the government to work towards realization of the April 2001 - Abuja, Nigeria commitment of allocating at least 15% of the annual budget to improve the health sector. This is crucial as it would go a long way in facilitating availability, accessibility, affordability of quality healthcare services for all Kenyans including marginalized populations like informal settlement dwellers.

Efforts should also be made to advocate for National Treasury's consideration of the devolved Health function when allocating shareable revenue to counties. At devolved level, County Governments should allocate enough resources to the Health docket - based on a clear understanding of resource needs with the view of effectively targeting the resources to service delivery that addresses the needs of the poor and vulnerable populations i.e. informal settlement dwellers

Strengthening citizens role to hold policy makers and duty bearers accountable through civic engagement approaches will go a long way in ensuring the above recommendations if adopted by the relevant actors, will be actualized thus contribute to quality healthcare for all citizens.

1. INTRODUCTION AND CONTEXT

1.1. Background

The Economic and Social rights Centre - HakiJamii has pioneered work on promoting social accountability in health sector governance in Kenya mostly undertaken through the organization, empowerment and consolidation of communities and non-state actors to meaningfully participate in health sector governance including the budget making processes, policy development and decision making towards improved service delivery. HakiJamii through past projects has provided leadership in effective citizen participation in crucial processes including the budget making process (and the public participation that comes with it), annual development plans, influencing county strategic plans, and ensuring proper delivery of health services through investing in a stronger Community Health workforce.

The work of civil society groups in the past few years focused on advocating for budget increase for the health sector in the counties. This has been achieved significantly in Mombasa and Kakamega counties; with a few other improvements have equally been noted in Makueni, Turkana, Meru, Kisii and a host of other counties. However, any such increase in healthcare spending has not contributed to an equal level of improvement in service delivery and enjoyment of health rights. Instead, concerns over inefficiency, infectiveness and low absorption of development funds have continued to be raised from both the supply side, and the demand side actors. In particular, public health facilities face major challenges including unavailability of storage facilities, insufficient human resources, vicious lack of essential drugs and commodities, equipment and mismanagement of funds and corruption. Although the constitution and devolution laws emphasize on involvement and the participation of citizens in making financial decisions and setting priorities, this process has been abused and citizens used to rubber stamp already concluded decisions.

HakiJamii therefore seeks to re-focus the attention of policymakers and other stakeholders towards an understanding of healthcare as a space in which primacy is afforded to core values and principles including human rights, human dignity, service, compassion and collective interests. The study builds on HakiJamii's previous engagements with county government health systems, and the gaps in health governance and accountability established in the process.

1.2. Purpose and Objectives

This study was commissioned to gather policy perspectives, and active community voices on access to healthcare within informal settlements, with the overall intention being to inform policy review, advocacy and programs that aim to improve access to quality public healthcare in the targeted informal settlements in Nairobi and Mombasa counties.

Specifically, the study sought to:

- **Establish the policy, structural and administrative gaps within the public health sector that hinder access to quality healthcare services by the marginalized community in the informal settlements.**
- **Determine the quality and scale of private healthcare provision against public health care within targeted informal settlements.**
- **Assess elements that propagates private healthcare provision in the informal settlements.**
- **Highlight the specific actions the government should take to ensure inclusivity and success of Universal Health Care Agenda particularly for the marginalized groups.**

1.3. Context of Study

1.3.1. Health Governance

The CoK 2010 provides for two levels of government, the National and the County Government. Since 2010, the leadership and governance of the Health sector has become more complex with the Sector now operating within a devolved system and at two levels of government i.e. National Government (Ministry of Health) and forty-Seven (47) County Governments. The two levels of government are distinct but interdependent and are supposed to operate through mutual consultation.

At National level, Ministry of Health formulates Health Policy; manages national referral services and coordinates capacity building and technical support to the entire sector. Whereas at County level, the County Government covers health service delivery aimed at ensuring the provision of proximate, easily accessible health services to citizens. The obligations of the county governments in the provision of both clinical and preventive health services therefore includes.

- addressing discrimination of the “low potential areas”.
- addressing problems of bureaucracy in matters of health service provision especially procurement related problems.

- promoting efficiency in the delivery of health services;
- addressing problems of low quality of health services.
- promote primary health care;
- control and regulate county health facilities and pharmacies;
- Provide ambulance services;
- Licensing and control of undertakings that sell food to the public;
- Cemeteries, funeral parlors and crematoria;
- and support Refuse removal, refuse dumps and solid waste disposal.

It is also worth noting **that CoK 2010 provides a framework for greater citizen participation for accountable governance across all sectors and social services**. Citizens participation is a critical aspect of democratic governance as it promotes accountability and improves service delivery by public officers; it also increases credibility between public officers; promotes active citizenship and provides a platform for greater diversity of citizens to contribute to public debate and decision making. It provides an opportunity for focused and prioritized community concerns to be addressed by public officials while creating citizens who are more aware of their community needs and how government responds to those needs. Citizens engagement can be actualized through processes like development planning, budgeting and public expenditure tracking.

These provisions of the CoK 2010 are further reflected in the Health Act of 2017, which explicitly states that;

> It is a fundamental duty of the State to observe, respect, protect, promote and fulfill the right to the highest attainable standard of health including reproductive health care and emergency medical treatment by inter alia - developing policies, laws and other measures necessary to protect, promote, improve and maintain the health and well-being of every person; ensuring the prioritization and adequate investment in research for health to promote technology and innovation in health care delivery;
>
> - ensuring the realization of the health-related rights and interests of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalized communities and members of particular ethnic, religious or cultural communities.
>
> - ensuring the provision of a health service package at all levels of the health care system, which shall include services addressing promotion, prevention, curative, palliative and rehabilitation, as well as physical and financial access to health care;

- ensuring adequate investment in research for health to promote technology and innovation in health care delivery.

Subsequent sections of the Act also spell out specific health rights and entitlements which includes the right to reproductive health services, the right to emergency medical treatment, and the right to accurate health information, amongst other rights.

These provisions of the law have been reflected in various strategic and operation frameworks such as the Health Sector Strategic Plans (both at National and County levels), the Community Health strategies, the County Integrated development Plans, the National Health Policy and various strategies for vertical programmes in health. The level of fidelity to the implementation, and the extent to which they have integrated special provisions to reach vulnerable populations such as those living in informal settlements remain to be explored.

1.3.2. The Health System in Kenya

The Kenyan health system is organized around six levels of care, that fit into four tiers, based on the scope and complexity of the services offered as illustrated herein.

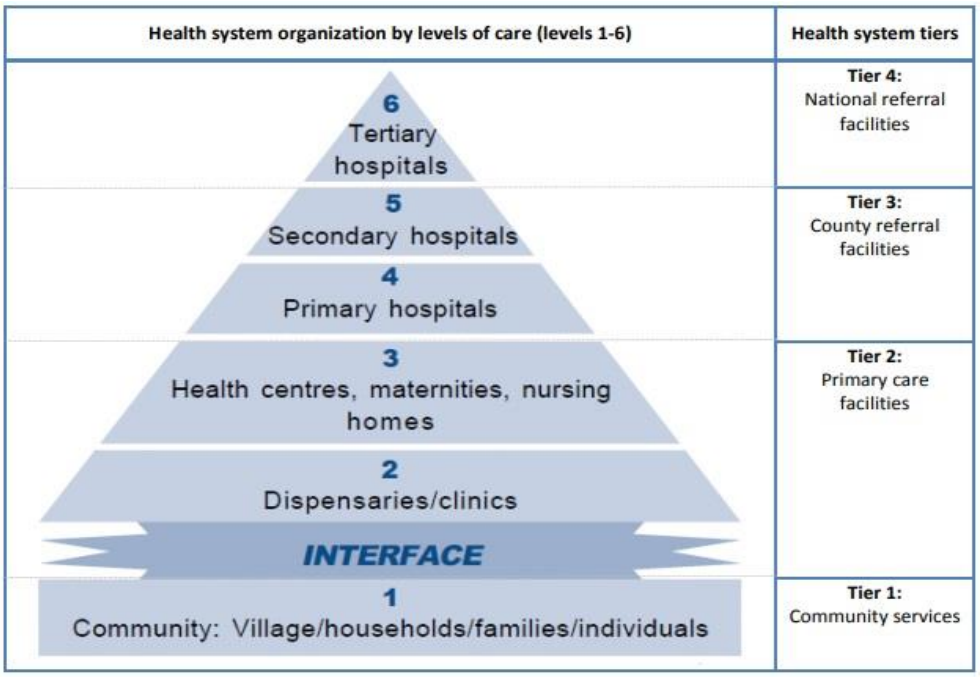


Figure 1: Kenya health care system with four tiers of care vis a vis the six levels of care[2]

The Kenya Health Policy 2012–2030 identified the need to strengthen the referral system as a way of improving efficiency in the health system and improving patient outcomes. Continuity of care across the four tiers depends on a well-functioning referral system, strong linkages between

[2] Source : https://www.measureevaluation.org › pima › at download › file

and across the service tiers and adequately resourced facilities according to the service standards and norm. A draft referral strategy was therefore developed in 2012 to operate the referral systems and guide the strengthening of linkages across the tiers of care for efficient health service delivery, as outlined in the Kenya Health Plan 2012–2030 and Kenya Health Sector Strategic And Investment Plan (KHSSP) 2012–2018.

Literature reviewed during the study highlighted interesting findings from a baseline[3] carried out in 2013 to assess the state of the referral system in Kenya. The results from the cross–sectional study, at that point in time suggested that although the need to strengthen the referral system was explicitly stated in the health policy and in the Health Sector Strategic and Investment Plan, many gaps still existed in the referral system. These gaps included;

- The absence of clear guidelines on referral processes,
- inadequately resourced facilities according the national service standards and norms,
- inadequate formal communication and transport mechanisms,
- poor relationships between referring and receiving facilities,
- lack of pro–poor protection mechanisms for emergency referrals,
- inadequate capacity to monitor the referral system and provide feedback,
- capacity gaps in data management

In the course of primary data collection, this study sought to further interrogate whether the informal settlement residents observed similar gaps within the Health System and if so, whether these gaps posed a challenge to their accessing the promise of equitable, affordable and quality healthcare and related services at the highest attainable standards.

Insights from a mapping exercise of Community Health Units commissioned by the Human Resource for Health (HRH) Advocacy Project in three sites including Kibera, indicate that communities have embraced the Community Health strategy and its contribution to improved health status. The exercise reveals that Community Health Workers (CHWs) have developed innovative ways to conduct referrals by using locally available means of transport, mobile phones and formation of referral networks. Although majority of CHWs receive support supervision, this support is not regular and does not reach all CHWs. The study interrogated the effectiveness of CHWs s in the two counties with findings indicating that CHWs do the heavy

[3] https://www.measureevaluation.org/pima/baseline-assessments/07rssbaselineassessment_rev.pdf

lifting in respect to health care provision within informal settlements as they are the eyes and ears of public health officers but are poorly facilitated.

Opportunities therefore exist to ensure ample motivation for the CHWs as they fill an important gap and thus make a major contribution to the success if the Community health Strategy.

1.3.3. The Emergence of Universal Health Coverage

Universal health coverage (UHC) has been adopted as Target 3.8 of the Sustainable Development Goals (SDGs), with a clear goal of ensuring that individuals and communities receive the health services they need without suffering financial hardship. This includes provision of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. Progress towards UHC will ensure progress towards other health related targets, and towards equity and social inclusion.

Kenya has adopted Universal Health Coverage as one of the Big Four priority Agenda with an aspiration that by 2022, all persons in Kenya will be able to use the essential services they need for their health and wellbeing through a single unified benefit package, without the risk of financial catastrophe.

The current epidemiological transition from communicable conditions to the triple burden of disease marked by emerging non-communicable conditions and injuries; coupled by efforts by the government to increase access through free maternity and primary healthcare services, has led to an increase in the demand and access to health services.

There have been additional efforts to increase access seen by an increased number of health facilities providing KEPH services from 41% to 55% between 2013 to 2018, increased staff and equipment through the managed equipment service at all levels, and expansion of maternity wings. The development of a health financing strategy that will ensure that the entire population is covered with some form of insurance is also underway, and there is an outright realization that increased access and demand for services, call for deliberate efforts to ensure that the services offered are of high quality.

For Kenya to achieve close to 100% UHC for all segments of population(both urban and rural), several strategic initiatives have to be put in place to progressively enable everyone to access the services that address the most important causes of disease and death, and ensure that the quality of these services is good enough to improve the health of Kenyans. Numerous efforts

have been made to ensure a steady rise towards UHC by designing and implementing health care policy reforms, yet a lot more can be done.

To increase access and demand for services, initiatives like **provision of free PHC services for all; free maternity services at all public health facilities; health insurance subsidies for the poor, vulnerable, the old; development of a health financing strategy that will ensure that the entire population is covered with some form of insurance; increase in staff and equipment through the managed equipment service at all levels, and expansion of maternity wings;** would need to be properly conceived and implemented by the various health-sector stakeholders as shown below;

The role played by all these stakeholders in the delivery of quality of health services is critical and must thus be perceived as complimentary to the system. Specifically, local NGOs in their diversity play the role of strengthening Community Health Workforce, influencing policy at county and national level, and ensuring accountability of resources allocated to health. A few NGOs have also invested in developing models for Community Based Health Insurance for populations living in informal urban settlements, and those in rural communities.

Other notable initiatives that target informal settlements includes **the Slum Upgrading project** which addresses social and economic challenges facing informal settlement dwellers to access health care services, with 11 mobile clinics established and operational. The country plans to put up a total of 100 clinics in 12 major towns.

1.3.4. Socio-economic and Demographic Dimensions of Informal Settlements

The global population in informal settlements is projected to rise to over 2 billion by 2020 with close to 85% of informal settlements being in cities of the global south (Habitat/WHO, 2010).

Among cities in sub-Saharan Africa with a million or more population, between 50 and 80% of the urban population lives in informal settlements (UN Habitat, 2014). In its draft 2020 Budget Policy Statement (BPS)[4], National Treasury noted that 22% of the population in the Kenya's five cities lives in informal settlements. The number of individuals living in informal settlements varies significantly by city, with 36% of residents in Nairobi living in informal settlements while 24% of Mombasa residents living in informal settlements. According to the census data, Nairobi county has a total of population of 4.39 million people, which means over 1.5 million people live in the city's informal settlements.

Several interrelated factors have driven the emergence of informal settlements in sub Saharan Africa countries inclusive of Kenya, some of which include population growth; rural-urban migration; lack of affordable housing; weak governance; economic vulnerability and low-wage jobs. The increase of the population in informal settlements continues to exert pressure on adequacy of social services calling for concerted efforts between Government, Private Sector and Citizens to each play their part in ensuring policy implementation, planning and urban management is realized for accountable service delivery. As the effect of the strain on social services like Water, Health and Sanitation immediately evident through the inadequacy in the status of key health indicators e.g. Access to Health Services; Clinical Preventive Services and Reproductive and Sexual Health services etc.

[4] https://www.treasury.go.ke/media-centre/news-updates/707-draft-2020-budget-policy-statement.html

2. METHODOLOGY AND APPROACH

The study embraced a descriptive cross-sectional participatory methodology that was qualitative in nature, having utilized both primary and secondary data sources. Desk review of relevant information was a central element of secondary data collection, while Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) with key stakeholders provided primary data collection which included the identification and ground-truthing of case studies.

2.1. Scope and focus

The study focused on selected Informal Settlements in Nairobi and Mombasa Counties. Thematically, the study was anchored on a human rights premise that regards health as a right and a public good, which duty bearer (national and sub-national governments) must do their best to make available to rights holders (citizens). In Nairobi, the study was focused on Kibera and Korogocho informal settlements whereas in Mombasa, the study focused on Kisauni informal settlement.

2.2. Trends Analysis

The first stage covered public and specialized reviews assessing the state of literature and discourse relating to public health care provision generally and in specific regards to informal settlements, assessed along the first three broad objectives of the study. This formed the basis of a common conclusion on the possible links, or lack of it, between the diminution of public health provision and the ascendancy of private health care provision Kenya and in informal settlements.

2.3. Application of PRISMA for developing thematic areas

The second layer of methodology was isolation of the common themes from the sporadic research reports. This was done using the Preferred Reporting Items for Systematic review and Meta-Analysis, generally referred to as the PRISMA model[5], used to carry out systematic reviews. Through this model, an understanding was arrived at of the discourse of healthcare as a human right and public good in Kenya, its opportunities and the limitations in developing a theory of change in informal settlements in the target counties.

[5] The Cochrane Collaboration defines a systematic review as a review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyze data from the studies that are included in the review. Statistical methods (meta-analysis) may or may not be used to analyze and summarize the results of the included studies. Meta-analysis refers to the use of statistical techniques in a systematic review to integrate the results of included studies.

2.4. Ground-truthing research analysis through KIIs and FGDs.

County-specific Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) with a select group of experts from all categories of actors engaged in healthcare policy development, delivery/management and advocacy were carried out which explored both the scope of theorization and perceptions on the state of healthcare provision, and the tripled questions guiding the research endeavor, as well as convergence and divergence from the 'official' framing of the state of public healthcare provisioning and the UHC agenda.

2.5. Case Studies

These were obtained through in-depth discussions with persons strategically placed to possess vital perspectives on the experiences of informal sector dwellers with health care provisioning, both public and private. Information produced was then cross-checked and compared through key informants' interviews and Focus Group Discussions to generate accurate case studies that reflect the reality of the situation.

2.6. Data Collection Methods, Sources and Sampling

The table below describes the methods used in the research synthesis and coordination as well as sources and sampling targets in Nairobi and Mombasa counties. These targets sought to gather enough responses in order to realize a representative and credible synthesis.

Method	Description	Sources	Sample target
Literature review	The documents reviewed encompassed all relevant research reports and available data related to healthcare provision	Secondary data sources, including: • GOK reports • Research reports • Area-specific data • Reports of County health departments	N/A
Stakeholder mapping	Developed a list of respondents for data collection using a pre-determined criterion	• GOK • HakiJamii • Healthcare providers • Research Think tanks • NSAs • Consultants	State actors Healthcare providers Research Think tanks NSAs
Partner interviews in Nairobi	Semi-structured interviews (KIIs and IDIs) using guides and checklists	• GOK • Research think tanks • Select NSAs engaged in healthcare advocacy • Healthcare providers	Resource persons based in Nairobi Representatives of key institutions & actors

Method	Description	Sources	Sample target
Field visits to counties	Semi-structured interviews (KIIs/IDIs & FGDs) conducted with key actors in healthcare provision and advocacy in the focus counties using guides & checklists.	• Selected members of the county health management organizations • Selected staff of stakeholder organizations engaged in healthcare provision and advocacy • Opinion leaders	Relevant actors and representatives of key institutions in focus counties: • Nairobi. • Mombasa The list of respondents will be attached.
Research validation roundtable	One research validation roundtable with key stakeholders	• HakiJamii • Sampled representatives of county health management teams • Experts • NSAs in healthcare advocacy	One workshop with participants from: • GOK • National and county health management teams • Experts • NSAs in health advocacy

2.7. Quality Control, Data Management and Ethical Considerations

To enhance the accuracy and validity of primary data, the study had the following key safeguards;

- Ensuring that the process of data collection was subjected to a series of back checks for correctness and consistency with the remote assistance of notifications from the data collection platform
- Obtaining approvals from local administration and sensitizing communities ahead of the survey to minimize incidences of non-response
- Providing respondents with the opportunity to accept or decline to be interviewed and further assure of confidentiality of responses.
- All RAs had a post-secondary education and proved to have participated in similar Data collection exercises. We used an established set of RAs who have worked with CHASP in other assignments. Where new RAs were brought on board appropriate references were sought from previous engagements.
- The RAs were assigned specific sites for which they were responsible for data collection. These areas were under a research coordinator who worked closely monitoring the data collection process throughout the exercise. The coordinators and the consulting team were

available to address any challenges and to trouble shoot any issues that arose from the use of the data collection tablets.

2.8. Gender Considerations

Throughout the study, consultants, Supervisors and participating Research assistants were committed to ensuring that basic minimums with regards to gender were always observed. Some of these considerations included:

- Gender balanced selection of Supervisors and Enumerators. This ensured that no gender-based biases were introduced by virtue of gender imbalances.
- With support from the Gender expert, the study team ensured that all questions, both at KII, FGD and Respondents levels had been analyzed for gender sensitive.

2.9. Limitations of Study

Considering the study applied qualitative approaches, the findings, conclusions and recommendations have therefore been generated through non-statistical inferences, and are at best perspectives and opinions of actors involved in the delivery of services (supply side perspectives), and those of the consumers of health services (demand side perspectives). While there have been significant attempts to utilize quantitative data available, most of the data sources were relied on Nation-wide studies which are too generalized and a lot less granulated to highlight the specific access issues within urban informal settlements. This study therefore only utilized service data that was available, and there are chances that some of such data could be due for updates and might be a slight shift from situation. Further triangulation of the findings is therefore recommended.

3. KEY FINDINGS

This section presents the findings of the study in relation to the context of informal settlements and against the three (3) core study objectives. The findings provide an understanding of healthcare provision in informal settlements, the motivations/ limitations for access to specific categories of health services by residents of informal settlements, and the policy provisions put in place by the government and the related gaps that are an impediment to access of public health care for residents of informal settlements.

3.1. RQ 1: Establish the policy, structural and administrative gaps within the public health sector that hinder access to quality healthcare services by the marginalized community in the informal settlements

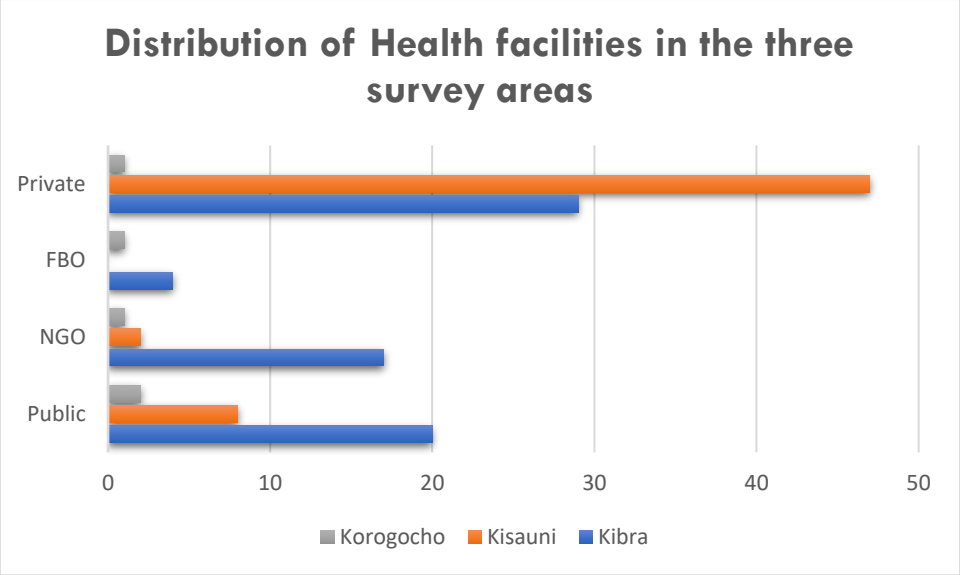
3.1.1. Structures for the Delivery of Healthcare services

The increase of the population in informal settlements continues to exert pressure on adequacy of social services calling for concerted efforts between Government, Private Sector and Citizens to each play their part in ensuring policy implementation, planning and urban management is realized for accountable service delivery. The effect of the strain on social services like Health is immediately evident through the inadequacy in the status of key indicators e.g. Access to Health Services, Clinical Preventive Services and Reproductive and Sexual Health services etc.

The unstructured nature and marginalization of informal settlements renders them underserved in terms of infrastructure development and access to basic amenities. In Nairobi, this is strongly manifested through health services where there's insufficient investment in health facilities (both infrastructure and human resources) within the informal settlements. The resultant effect being that government health facilities are inaccessible to many informal settlement dwellers thus limiting access and utilization of essential health services.

According to the Kenyan Master Facility List[6] (MFL), there are a total of 990 health facilities in Nairobi. About 139 of these facilities are owned by the public sector, 640 fall under ownership of the commercial private sector and 102 are owned by FBOs, while 109 are owned by NGOs. In Mombasa, there are a total of 306 health facilities, 55 are owned by the public sector, 14 by FBOs, 10 by NGOs while the majority 227 are owned by the Private sector. This is indicative of the fact that the health sector is indeed driven by commercial private service providers. Data reviewed from the MFL confirms that the trend holds in the distribution of registered health facilities in the 3 survey informal settlements as illustrated below:

[6] http://kmhfl.health.go.ke/ - includes all officially registered health facilities in the country



Further assessment of the available health services in expansive Kibera reveals that the existent public health facilities cannot sustain the increasing pressure from Kenya's largest informal settlement whose population was documented at 185,777[7] during the 2019 Kenya Population and Housing Census. The 70 registered health facilities imply a health provider to patient ratio of 1: 2,654 for the majority level 2 facilities comprising of dispensaries, mainly offering Outpatient services, VCT services, Tuberculosis services, Laboratory Services, Well baby Clinics, Antenatal and Postnatal services, Pharmacy, Counselling services and Curative treatment, which issue referral letters to other facilities. The situation in Mombasa's Kisauni is worse where the overall population in the sub county is 291,930 and the registered health facilities are 47 implying a health provider to patient ratio of 1: 6,211.

The absence of adequate public healthcare in informal settlements like Kibera has thus presented an opportunity for alternative service providers to develop healthcare solutions responding to the fast-growing population. Residents have thus resulted to seeking healthcare services at private, NGO or faith-based facilities. Interactions with informal settlement dwellers revealed that there exist several unregistered health facilities which are unregulated

In Kibera, there are several unlicensed health practitioners. Medicine dispensed by unqualified people and sold over the counter in shops. This was captured by a respondents' remarks "hapa kwetu tunauziwa madawa hata kwa duka"

This study also observed that most of the clinics in Kibera are always conveniently closed during inspection by the Pharmacy & Poisons Board (PPB), in a way that makes it obvious the private players often have prior knowledge of such inspection visits

[7] https://www.knbs.or.ke/?wpdmpro=2019-kenya-population-and-housing-census-volume-i-population-by-county-and-sub-county

and offer low quality of services at a cost[i] that many residents consider affordable and convenient.

An interrogation of one of the public facilities accessible to informal settlement dwellers in Kisauni, Mombasa County i.e. Junda Dispensary, revealed that despite the facility being generally well equipped, informal settlement dwellers do not receive comprehensive treatment given that essential drugs are often lacking, thereby occasioning much desperation to the residents. The study also observed that human resource constraints hamper delivery of quality medical services, with very few professionals attending to too many patients. The workload of one medical officer can be as high as 100 patients a day, with the facility being overwhelmed, calling for patients to come in very early in order to be attended to. A good number of ante natal clinic patients who arrive after 07h00 are often turned away with referrals made to higher level public medical facilities for all inpatient cases or neighboring private clinics. The private clinics vary in degree of medical equipment, are plenty and offer a broad range of services. A good number of such facilities are owned by workers in public health facilities including clinical officers, nurses and even nurse aides.

3.1.2. Healthcare Reforms and their contribution to access for the urban poor

Several healthcare reforms have over time been put in place by GoK to extend financial risk protection and service coverage to citizens. These reforms can broadly be classified as user – fee reform and health insurance reforms, with the intention being to extend the proportion of the population with Financial Risk Protection thus enable access to all citizens including informal settlement dwellers.

USER-FEE REFORMS	HEALTH INSURANCE REFORMS
• **1963:** User fees, that had been previously introduced by the colonial government, were abolished; health sector was then predominantly tax financed. • **1989:** User fees reintroduced in public hospitals and peripheral health facilities (health centres and dispensaries) that offer outpatient primary healthcare services. User fees abolished later that year due to social justice concerns. • **1992:** User fees reintroduced again because of budgetary constraints. • **2003:** The Government of Kenya abolished user fee for maternity care under the Free Maternity Service policy in all public health facilities, a move to make maternity services accessible and affordable, and to reduce maternal and perinatal mortality	• **1966:** The National Hospital Insurance Fund (NHIF) was established as a department of the Ministry of Health (MOH) to provide health insurance cover to the formal sector. Salaried individuals contributed a flat premium rate and were entitled to an inpatient benefit package. • **1972:** The law that governs the NHIF was amended to extend insurance coverage to individuals in the informal sector. • **1990:** The law was further amended to introduce a graduated premium payment structure. • **1998:** The original law was repealed and replaced with the NHIF Act of 1998 that transformed the institution from a department of the MOH to an autonomous state corporation. • **2014:** The Health Insurance Subsidy for the Poor launched as a comprehensive, fully

USER-FEE REFORMS	HEALTH INSURANCE REFORMS
• **2004:** User fees abolished in public peripheral health facilities, except for a flat registration fee of Kenyan shillings (KES) 10 in dispensaries and KES20 in health centres. Public hospitals continued to charge user fees under a cost-sharing arrangement where hospitals received partial supply-side subsidies from the central government and charged fees to users of healthcare services. • **2013:** After the election of a new government, user fees were completely abolished in health centres and dispensaries. A free maternity programme was introduced that removed user fees for deliveries in all public facilities.	subsidized, health insurance program for selected poor orphans and vulnerable children—benefiting from the government's cash transfer program • **2015:** The NHIF Act was amended to revise premiums upwards. The NHIF expanded its benefit package from inpatient only, to include outpatient services as well as a raft of what has been termed special packages (radiology, cancer care, ambulance services, surgical care, chronic care, maternity care, overseas travel, renal dialysis and kidney transplant).

Despite the above reforms, the study findings point to inequity and possibility that the urban poor are still left behind as regards affordability and access to public healthcare as various underlying factors still undermine the affordability of public healthcare services. An assessment of the application of the user fees waiver at the public healthcare facilities in both Nairobi and Mombasa counties revealed that despite the waived primary consultation fees, other costs exist associated with secondary tests and administration of medicine thus undermining the initial intent of the user fee reforms. On the most recently documented health insurance reform, the study determined that the 2018 upward revision of premiums was perceived as unaffordable to informal settlement dwellers thus inhibiting their subscription to NHIF with the resultant effect being inaccessibility to public healthcare services.

3.1.3. Impact of devolution on health service delivery in Kenya

3.1.3.1. Prioritization of Healthcare

The 2010 CoK introduced the concept of devolution of both resources and power from the national government to 47 counties, with Health service delivery being devolved as a function of the county governments. Devolution of healthcare services allows county governments to design innovative models and interventions that suit the unique health sector needs in their contexts; sufficiently scope to determine their health system and citizen priorities; make autonomous and quick decisions on resource mobilisation, subsector resource allocation and spending, and management of arising issues.

A quick assessment of the impact of devolution of health service delivery in both Nairobi and Mombasa counties revealed that both counties prioritised strengthening of healthcare delivery

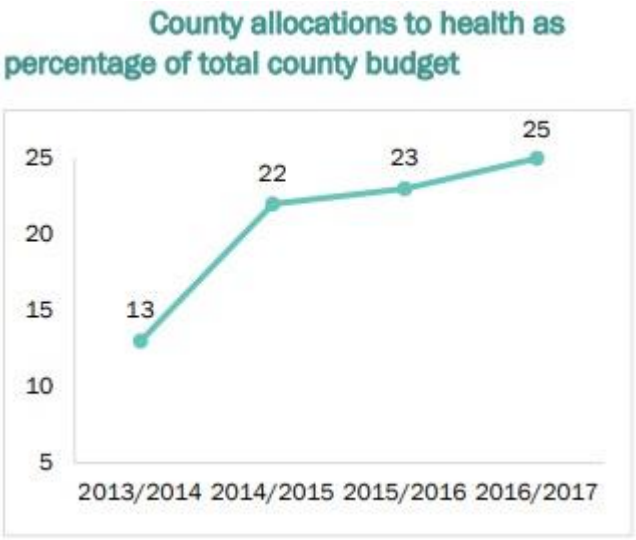
within their County Integrated Development Plans[8] [9] with Mombasa county's focus being on provision of integrated and high quality Promotive, Preventive, Curative and Rehabilitative health care services with deliberate plans in place to strengthen and upgrade health infrastructure; enhance capacity to offer quality, cost effective, efficient referral services in all health facilities; provide efficient and cost effective health and diagnostic services; and promote community participation and co-operative governance in health. Some highlights include strategies that would ensure accessible and quality healthcare to informal settlement dwellers in Kisauni and its environs such as the renovation of Kisauni dispensary; construction and equipping one new county referral hospital in Kisauni. However, realisation of this has been marred by various challenges as cited in the Mombasa County Annual Progress report[10] which identifies key challenges being cash flow; inadequate numbers of health workers of some cadres ; low coverage of community units; poor referral systems especially from remote or far to reach areas; delayed enactment of Health Bill into Law thus hampering sector oversight and the absence of a comprehensive integrated information system in the health. Nairobi County's focus is on providing quality healthcare services that is accessible, equitable and sustainable to the population with deliberate strategies in place to strengthen preventative and curative care for all citizens.

This goes to show that devolution provided opportunities for county governments to critically think about, prioritise and craft deliberate strategies towards ensuring healthcare services are accessible to citizens in line with the ambitions of UHC.

[8] http://www.mombasa.go.ke/wp-content/uploads/2018/11/MSA-FINAL-CIDP-2018-22.pdf
[9] https://cog.go.ke/media-multimedia/reportss/category/106-county-integrated-development-plans-2018-2022?download=325:nairobi-county-integrated-development-plan-2018-2022

[10] http://www.mombasa.go.ke/wp-content/uploads/2019/09/COUNTY-ANNUAL-PROGRESS-REPORT1819.pdf

3.1.3.2. Budgetary allocations to healthcare



County allocations to health have been seen to increase since devolution with trend being visibly upward. Immediately after devolution, county budget allocations to health were insufficient relative to the counties' new responsibilities, but this has changed as illustrated in the County allocations to health herein. The Kenya Health Financing System Assessment, 2108 estimated that health accounted for 36 percent of the functions newly under county control. However, total county allocations to health only amounted to KES 42 billion, or 13 percent of total county budgets. Since then, counties have steadily increased allocations to the health sector. County governments' health allocations more than doubled from KES 42 billion reported in 2013/14 to about K 92 billion in 2016/17. County health budgets in 2014/15, 2015/16, and 2016/17 were approximately 22 percent, 23 percent, and 25 percent of total county budgets, respectively.

Despite County allocations to health increase since devolution, implementation of the county health system remains a challenge due to factors that threaten quality service delivery and gains made in the sector. Some challenges cited include inconsistent allocation of funds to the counties by national government thus leading to stalling of functions at the county level, further creating inefficiencies. For example, the Health Sector Services Fund - HSSF[11] allocation expected to be disbursed every quarter from the national government directly to health facilities countrywide. However, there have been instances where certain facilities receive only one or two disbursements in a year; greatly interrupting the running of the facility as these funds are intended to primarily run the facility and cater for any arising emergencies. The delay in allocations has been rampant that county governments have viewed this as a political strategy to sabotage devolved health delivery so that citizens can push for the function to revert to the national government. Furthermore, literature reviewed indicates that most county governments have no clear procurement plans in place for the purchase of medical supplies. County governments are under no obligation to procure from the Kenya Medical Supplies Authority (KEMSA)

[11] HSSF - a revolving fund that provides direct cash transfers to primary health care facilities that include dispensaries and health centres. The local communities represented by the Health Facility Management Committee (HFMC) manage the funds received and prioritize their use according to health needs.

which has been enhancing economies of scale while also monitoring the efficacy of the drugs for purposes of continuous improvement. The independent procurement by county governments has led to instances of corruption as county officials procure medical supplies of questionable quality at inflated prices. This is essence affects the quality of service delivery in these pubic facilities as efficacy of drugs is questionable and budgets run out before addressing the citizens needs thus affecting the sustainability of healthcare service delivery at the county level.

It is however worth noting that in response to the county governments inefficient procurement, KEMSA has launched a new business model that embraces the devolved system by putting systems and structures in place to ensure that supply of medical commodities to public health facilities continues uninterrupted. The new not-for-profit self-sustaining commercial business model enables the county health facilities to order and pay for their medical commodities on a demand driven supply system.

3.1.4. Civic Participation in Health Services

Despite the regulatory frameworks and the opportunities created for citizens engagement in the health sector governance, informal settlement dwellers appear to be disenfranchised in Healthcare planning as their participation is episodic and cosmetic. The respondents observed that there has been a general improvement in public participation during the budgeting process as compared to the pre-devolution era but their views, needs and priorities do not necessarily make it to the output of the budgeting process. Health budget tracking was observed to be a major gap as respondents in both Mombasa and Nairobi attested that Budget Implementation Reports were not readily accessible. The study determined that out of 47 counties, only Baringo and Makueni have provided Budget Implementation Reports[12] [13].

Civil Society Organizations focused on Health have time and again prepared their own shadow Health Sector budget implementation reports which the county governments constantly reference. One respondent observed: ***"Its anomalous that a number of county governments actually use CSO reports on budget tracking to demonstrate their own performance!"*** The lack of citizens engagement in tracking budget implementation and verifying these reports, thus provides a window for corruption within the Health sector. Lack of awareness among informal settlement dwellers on how to engage in the Development Planning process or how to plug into

[12] http://www.baringo.go.ke/images/downloads/Budget_Documents/Quaterly-Reports/Reports-quarterly-Implementation-2018-19/1st-Quarter-Budget-Implementation-Report-Final-Final.pdf

[13] https://makueni.go.ke/reports/makueni-county-fy201819-budget-implementation-report/

key policy discussions has been cited as a challenge that inhibits residents of informal settlements from taking up their active citizenship role.

It would therefore be useful to equip residents of informal settlements with the right knowledge, information and tools to activate their engagement in the development planning processes, as an avenue to voice out their needs and priorities.

The respondents from both Mombasa and Nairobi counties observed that civic engagement forums would be a good avenue to communicate the challenges they face in accessing the limited public facilities i.e. the bulging informal settlement population versus the few public health facilities. They also observed that the absence of essential medicines and the poor infrastructure within informal settlements not only poses a public health challenge but also renders it impossible for the residents to access ambulance services during emergencies due to the hard to reach areas within the informal settlements. As such, their dreams of access to public facilities within relative proximity to their homes, are dashed implying that quality health care remains an unresolved challenge.

The FGDs highlighted similar complaints in both informal settlements on lack of enough public health facilities with limited services. Participants indicated that where existent, essential medicines were unavailable in public hospitals leaving them to seek options in commercial pharmacies and private hospitals.

Ambulance services were inaccessible with a case cited of a mother whose child died while she was on the queue at Mbagathi hospital. She was practically chased from the hospital and had to carrying her deceased baby without the hospital management caring to provide an ambulance for her.

In Korogocho and Kibra, the participants observed that expectant mothers suffer a lot during delivery because they lack access to ambulance services.

3.1.5. Policy Barriers to Access of Healthcare Services within Informal Settlements

The idea that all people are entitled to have the physical needs of their bodies satisfied is at the heart of the human rights movement. This includes the right to the highest attainable standard of physical and mental health, which comprises access to all medical services, sanitation, adequate food, decent housing, healthy working conditions, and a clean environment. The Universal Declaration of Human Rights (UDHR) articulates the right to adequate health in Article 25 i.e. "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care…"[ii] Further, it contends that States must also take action to ensure that all citizens enjoy an adequate standard of living. It recognizes food, clothing, housing, health care and social services as essential

components of a standard of living adequate for health and well-being.[iii] Defining the precise standards that must evaluate these components is difficult since States with different economic and social histories and capacities have different understandings of an "adequate standard of living." A human rights-based approach (HRBA) to health focuses attention and provides strategies and solutions to redress inequalities, discriminatory practices (both real and perceived) and unjust power relations, which are often at the heart of inequitable health outcomes. It defines health as a "right" rather than an entitlement or "need". Human rights are strongly linked to the concept of social determinants.[iv]

Cognizant of the International policies and frameworks related to healthcare, the government of Kenya has adopted and enacted several policies anchored in the Constitution of Kenya 2010 (CoK 2010) to ensure the Universal Health Coverage (UHC) for all citizens. CoK 2010 provides the overarching legal framework to ensure a comprehensive rights-based approach to health services delivery, it states that a person shall not be denied emergency medical treatment and that the State shall provide appropriate social security to persons who are unable to support themselves and their dependents

To operationalize the comprehensive rights-based approach to health services delivery, the Government of Kenya developed the Kenya Health Policy[v] 2014–2030. The policy strives to operationalize the objects of devolution as it recognizes the right of communities to manage their own health affairs and to further their development; protecting and promoting the health interests and rights of minorities and marginalized communities, including informal settlements and under-served populations; promoting social and economic development and the provision of proximate, easily accessible health services throughout Kenya. The country's strong political commitment to UHC is embodied in the governments big 4 agenda that includes healthcare for all as one of the key development priorities. The installation of UHC as a country with a view of ensuring health policy goal has highlighted the need to monitor and to track progress over time ensuring that quality healthcare is easily accessible to all Kenyans by the year 2022.

Despite the progressive policies, it has been observed that the government is still unable to provide universal health coverage for her citizens. A policy brief on the status towards attainment of Universal Health Coverage indicates that slow progress towards UHC is symptomatic of weaknesses in all health system functions, including a consistently underfunded health sector and a health system heavily reliant on donor funds and out of pocket payments. The National Hospital Insurance Fund (NHIF)[vi] was rolled out as a social security initiative aimed at providing accessible, affordable, sustainable and quality health insurance for all Kenyans. The scheme is based on voluntary payments as a pathway to UHC. The reliance on voluntary

payment has been cited as a contributing factor to the country's slow UHC progress, as the voluntary contributions model cannot sustain the health demands of Kenya, due to the rampant poverty levels and economic vulnerability of a majority of Kenyans, thus rendering NHIF subscription far on the priority list of informal settlement residents.

NHIF was envisaged as being a ray of hope for the informal settlement populace access to quality, affordable and accessible health care services; the study however observed that residents of informal settlements were unaware of NHIF, how to subscribe to it and what benefits accrue from its membership. Such that, residents of informal settlements have potentially excluded themselves from the main pathway to accessible, affordable, sustainable and quality healthcare due to lack of information on the medical scheme.

The study observed that of the 15 respondents in the FGD Kibra, only 2 had NHIF cards while in Korogocho, only 1 person had the card, but it was dormant. Further to this, respondents were unaware of how NHIF works. A notable case was in Korogocho where a participant observed that "NHIF is just like KRA".

In both Kibra and Korogocho, respondents were not clear on what NHIF covers, as such they indicated that they opt for other affordable services like M-tiba (a mobile phone based health finance platform, integrating payments and revolutionizing health schemes to drive healthcare inclusion in Africa)

Residents of Kibra observed that they also get medication through installment payment, such that if one does not have the money to pay up for the next day's dose, one is likely to skip a dose or completely stop medication.

Additionally, findings from the survey revealed that informal settlement residents perceive health as a right only on paper but not in practice. Findings from Kisauni, Mombasa county indicated that informal settlement dwellers feeling was that if health was indeed a right, the first priority of the Government would have been in establishing physical infrastructure for healthcare delivery within relative proximity e.g. every ward to enable access for all. However, this is a far-off dream as minimal government investment has been set aside for development of Health infrastructure in informal settlements. Given the paucity of facilities, it is not possible for health as a right to be realized. It was also observed streamlining of payment mechanisms for health services in public facilities may have been well intended but poses a challenge as all patients, including emergency cases, have to make payments through MPESA mobile money transfer which not all patients can obtain immediately and in addition, attracts transactional costs given that these payments have to be made for various services separately rather than as a consolidated bill. Regarding the challenges faced in accessing Health as a Human right, one respondent ruefully noted: "***Utekelezaji umekuwa donda sugu***" i.e. "***Implementation has become a***

***chronic wound.*"** It was further observed that the few accessible public health facilities have too many patients being attended to by few professionals, as such many miss out on health services. The Government's Linda Mama[14] initiative despite being free to access, is beset by many administrative challenges at the point of service, which require attention if the intended outcome is to be realised. For example, Linda mama works through capitation and patients may not be accepted at higher-level public health facilities if their initial point of registration was a lower-level facility. The respondents however observed that with the right implementation framework, policies like UHC can indeed be actualized within their counties given that other counties e.g. Makueni had put in place clear implementation frameworks and addressed issues of corruption along the Healthcare delivery chain.

3.2. RQ2: Determine the quality and scale of private healthcare provision against public health care within targeted informal settlements

3.2.1. Key Health Sector Actors within informal settlements

Despite the limited public healthcare facilities in informal settlements, alternative healthcare providers exist that serve to address the resident's needs. A stakeholder mapping exercise of active health care providers in informal settlements in Nairobi and Mombasa highlighted four major classifications i.e. Public Health facilities; NGO run/development aid facilities; Faith Based organization/Mission sponsored facilities and Private health care facilities.

Table 1: Classification of Healthcare players in Kibera, Korogocho & Kisauni

Public Facilities	Government owned and operated
NGO run / development aid facilities	These offer comprehensive basic healthcare and maternity services integrated with the management of chronic diseases like HIV, targeting one of the most vulnerable populations.
Faith Based Organizations/ Mission sponsored:	These are community-based outreach programs which extends provision of medical services, nutrition, counseling and capacity building for vulnerable groups
Private Service Providers	These offer health services commercially to the general population

[14] **Linda Mama** is a basic healthcare package that targets expectant mothers who are otherwise unable to pay for healthcare services.

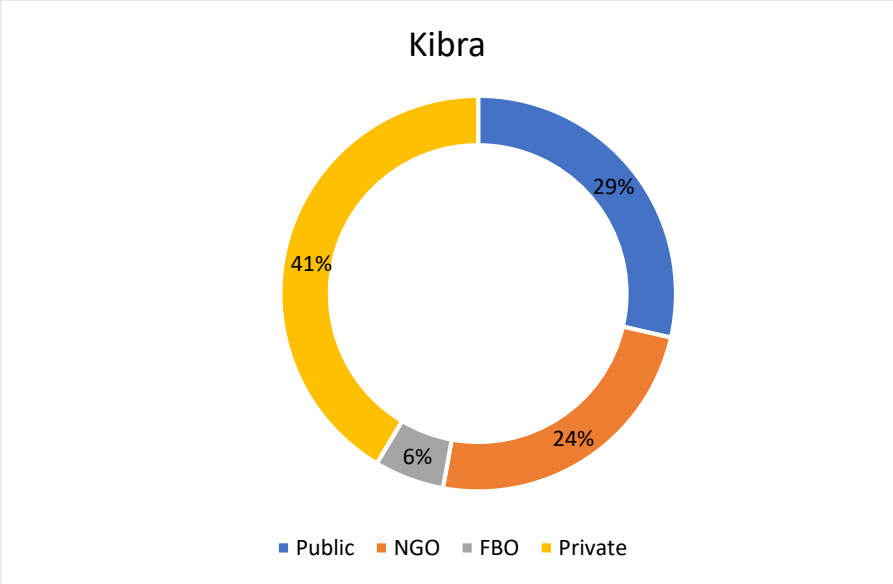
A survey conducted by the African Population and Health Research Center(APHRC) 2019 indicates that that many residents of informal settlements frequented public and private not-for-profit facilities for treatment of childhood illnesses, while they tend to use private for-profit for maternal delivery. The survey revealed that most of the providers serving informal settlements residents operated levels 2 facilities (i.e. offering primary care services). Four of the six public facilities were health centres while one was a dispensary. Of all the private providers, 81% were clinics, 9% dispensaries and 3% health centres[vii]

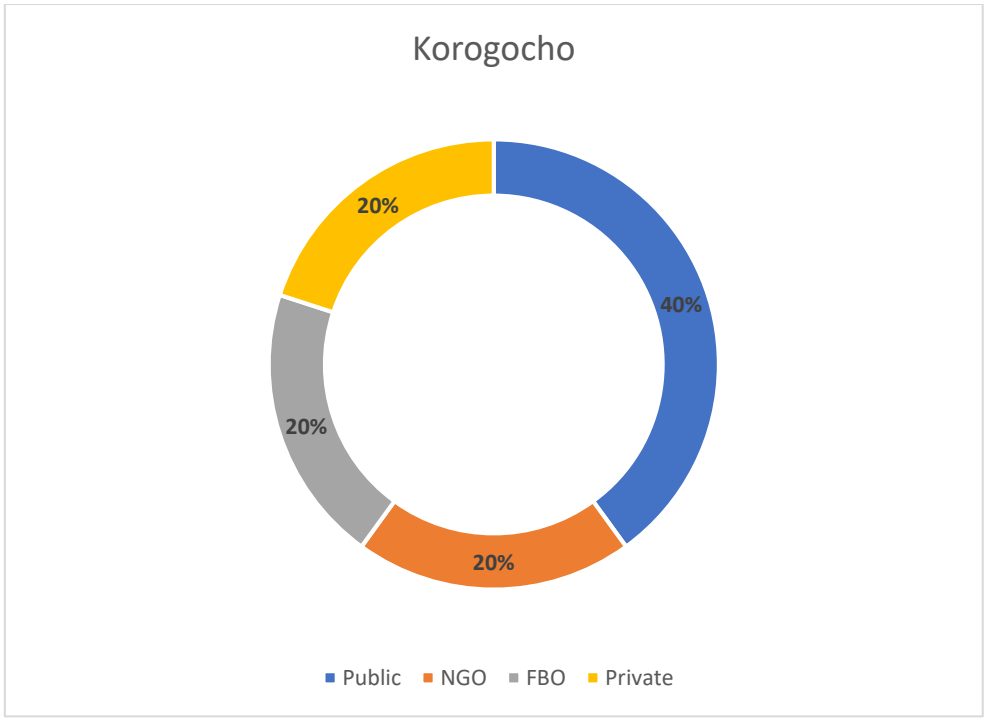
This information was further validated by the FGD respondents who observed that their economic vulnerability forces them to seek alternative healthcare that can easily be accessed on a needs by needs basis, for they do not enjoy the luxury of savings or extra income to channel towards healthcare and health insurance. The respondents observed that informal settlements thrive on micro credit, as such its practical to access services of a private healthcare provider who accepts some level of flexibility in payment for services rendered whilst ensuring privacy. The cost of healthcare in public facilities was cited as a prohibitive factor to informal settlement resident's access to quality healthcare. For instance, the study findings from Mombasa County indicate that services at health facilities run by NGOs/charities are free while in public facilities, many services are actually paid for in cash. Some basic preventive /protective health commodities that are expected to be free at public facilities such as condoms and gloves in HIV management - are often unavailable thereby putting lives of both patients and caregivers at risk. Within the public facilities, Donor-funded clinics exist for TB and HIV/AIDS related services, where drugs including ARV drugs are free. Testing costs for infectious diseases like Malaria are higher because patients now pay 100% of the costs. Despite the low registration costs of KES 50, other many payments exist for accessing different services even after registration, e.g. laboratory tests. Under 5 services are free during clinics and scheduled inoculations. After the inoculations, all other ailments are paid for at cost in full.

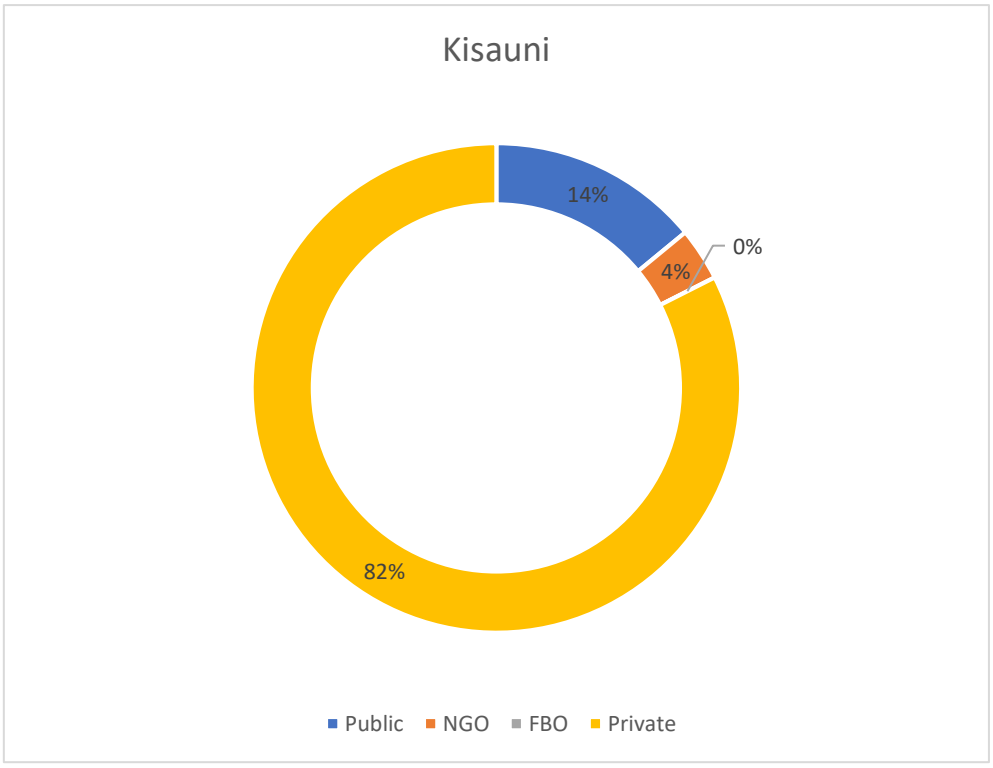
The afore-mentioned factors coupled with the inaccessibility of public healthcare facilities to serve the rapidly growing population are contributing factors in the rise in private healthcare provision in the informal settlements. It is however interesting to note that despite these factors compelling residents of informal settlements to seek private healthcare, there was a general observation that few of these private facilities offer quality healthcare as a good number are unregulated. It was thus observed that private healthcare provision in the informal settlements is propagated by the need for accessible, convenient, private and flexible services.

3.3. RQ3: Assess elements that propagate the dominance of the private players in the provision of healthcare in the informal settlements

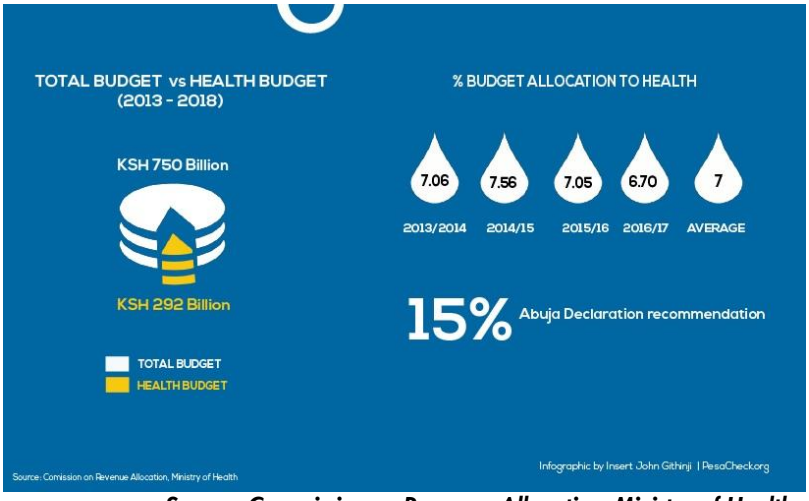
a) **Physical access to health facilities:** A prerequisite condition to addressing the healthcare needs of the increasing population in informal settlements is the availability of well-equipped Healthcare facilities and Personnel. Given that healthcare is essentially a basic service, the government has a responsibility to ensure that health facilities must be physically available and well equipped with personnel, equipment and medicines. Literature reviewed during the study unearthed the fact that public health facilities constitute only 1% of those accessed by residents of informal settlements in Nairobi, of which the public health facilities are characterized by long queues, shortage or lack of drugs, shortage of professional personnel and frequent strikes by health personnel. This begs the question on the governments investment in the health sector and presents opportunities for private players to set up healthcare facilities that are responding to the socio-economic context in informal settlements in a bid to present readily accessible healthcare conveniently located within the informal settlements. The study observed that in informal settlements in Nairobi and Mombasa counties, a significant number of private clinics have mushroomed and are providing primary healthcare services.] as illustrated in the three informal settlements below:




Korogocho
20%
40%
20%
20%
Public
NGO
FBO
Private


Kisauni
14%
0%
4%
82%
Public
NGO
FBO
Private

b) **Inadequate investment in health:** Kenya's annual budgetary allocations ranged between 6.7% and 7.567% of the total budget between 2013 to 2017, which is way below the recommended threshold as agreed upon by AU states in April 2001, during the Abuja declaration that pledged to set a target of allocating at least 15% of AU members states annual budget to improve the health sector. Kenya (a signatory to the Abuja Declaration) is still yet to meet the commitment and continues to underfund the health sector with the health system being heavily reliant on donor funds and out of pocket payments.



Source: Commission on Revenue Allocation, Ministry of Health

The reliance on voluntary NHIF payments as a pathway to UHC has rendered the programmes take off slow. The onset of the devolved system of governance presented possibilities for more investment into service delivery through an informed and coordinated process that seeks to set budgets based on county priorities.

Need therefore exists to advocate for National Treasury's consideration of the devolved Health function when allocating shareable revenue to counties, in a bid to ensure that they have enough resources to meet their specific health and service delivery needs. Additionally, County Governments need to allocate enough resources to the Health docket at county level - based on a clear understanding of resource needs with the view of effectively targeting the resources to poor and vulnerable populations i.e. informal settlements.

Counties can consider establishing taxation regimes premised on the allocations from national government. This would be a financial gap filling measure as opposed to a dedicated effort towards self-sufficiency.

c) **Health Financing:** As illustrated in preceding sections, the study observed that the primary vehicle to finance the UHC agenda is NHIF, which is underutilized coupled with citizens lack of awareness on the benefits and modalities. As NHIF strives to expand in

terms of both population coverage and the benefits package, both equity and financial sustainability considerations must be considered in establishing appropriate premium rates, that ensures resources to subsidize coverage for the poor and vulnerable are available. The study determined that civil servants and formal sector employees, enjoy superior benefits packages in comparison to independent contributors from the informal sector. This is a clear indication on the need to harmonize benefits across the socio-economic segments to allow equal access to health services. The inability of NHIF to respond to the needs of informal settlement dwellers thus exposes them to other available health financing mechanisms propagated by private healthcare providers including access to healthcare services through micro-credit that enables dispensing of medication daily.

Opportunities exists to strengthen NHIF's ability to effectively play its role as a social health insurer by increasing enrollment, with particular emphasis on enrolling the informal settlements populace; pooling resources across schemes thus cushioning vulnerable populations; improving payment mechanisms to better control both cost and quality; and making necessary institutional and legal reforms.

d) Poor Policy Implementation: Despite the government's commitment to rolling out the UHC, the study observed that implementation of certain policies was weak and uncoordinated. This was evidenced by the disparities in the pathways to access to healthcare in public and private healthcare facilities. To illustrate this, the study references Mombasa County where there appears to be a missing link in the intended access to quality healthcare through NHIF. Despite citizens having a right to access quality healthcare through subscription to the NHIF scheme, they regrettably are limited by the extent of the services they can explore, with a glaring contradiction in the fact that public health facilities usually lack capitation for NHIF cover; whereas private health facilities which use the claims system with the same publicly supported NHIF scheme, can offer access to health care all year round. The daily service limit is however capped at KES 1500 which can barely cater for doctor's consultation fees and initial tests, thus forcing citizens to dig into their pockets and top up for any additional tests and prescribed medication. These factors render the scheme impractical to the needs of informal settlement residents, as the top up fee to purchase medication is not within their reach. The resultant effect was a feeling that NHIF s goal is not quality healthcare for all but for a few as illustrated through a survey respondent's comment ***"Basically this amounts to "NHIF using the poor to avail healthcare to the rich".***

In the same county, the Beyond Zero Campaign ordered for containers for mobile clinics for 9 informal settlements in 6 sub-counties which were handed over to the county Government in 2014. To date the containers, remain idle and unused, being viewed as a wasted resource and contributor to the non- achievement of the goal of the campaign. The same was observed with the Managed Equipment Services project (MES) whose intention was noble in addressing the medical equipment challenge at County Health facilities but later turned into a veritable mess, with no need's assessment having been done prior to procurement of equipment. The result is that most of the equipment leased is being paid for by the counties upfront through deductions at source, but lies idle, with no competent personnel trained to handle them.

The study observes that getting policy implementation right is critically important as its failure is costly and can cause disruption for ordinary citizens. Policy makers can therefore benefit from being clear about the problem given that high-level policy goals e.g. NHIF needs to be matched with analysis of what problem government is trying to tackle and used to make good judgements on where to focus attention. For instance, the most vulnerable in the society do need social protection rather than premium-based regular contributions. It is therefore important that the government explores possibilities to expand access to quality and affordable health care for all, regardless of financial capability.

e) A Disjointed Referral System

The study determined that despite the country's referral system intention to be a mechanism for the effective management of health needs comprehensively, challenges on information management for case follow up in some instances renders the system ineffective. Findings from the FGDs in Mombasa revealed that services for HIV/AIDS patients on transit continue to be provided but many miss out in the absence of referral letters from their traditional points of service as an integrated Health Information Systems linking patient data is still a gap. The respondents observed that in cases where such patients lapsed/ defaulted on collection of their medication, they were forced to pay to obtain services. In addition, an element of commercialism which started as an incentive has crept into the HIV/AIDS treatment programs, wherein some CHVs are paid token amounts to bring patients to health facilities. This has resulted in "poaching" of patients or "hiring" proxies to collect ARV drugs on behalf of patients. Such cases highlight the inefficiencies of a referral system that can be addressed through prudent Health

information Management. One thoroughly disappointed participant observed that "***Afya yangu ni muhimu kuliko pesa. Pesa yako inaweza kunirudisha nyuma. Mwenye akili ndogo anaweza kujiingiza kwa hiyo mtego kwa haraka sana." Michael Musyo*** i.e. ***"My health is more important than money. Your money can set me back. The smallest mind can quickly get into that trap." Michael Musyo***

4. CONCLUSIONS & RECOMMENDATIONS

The study findings reveal that the enjoyment of health care as a public good remains a far-off reality to informal settlement dwellers given the myriad factors hampering access and affordability. These factors have been propagated by the continued absence of a supportive framework for citizens to engage and participate in priority setting during Health sector planning processes. Deliberate strategies need to be put in place to activate citizens engagement in tracking policy implementation to ensure policy objectives are realised and that affordable, quality healthcare is readily accessible to all citizens including typically marginalized groups including informal settlement dwellers. The recommendations below can therefore act as a starting point towards the push for access to health as a public good for residents of informal settlements:

4.1. Community Participation in Healthcare

There should be a well-structured, adequately funded, participatory and people-oriented policy on public participation in health, that the public should be made aware of, so as to enhance their participation. Similarly, there should be convenings to discuss health budgets and implementations in order to help them understand and contribute to the budget process, facilitate development and adoption of sound health investment priorities. There is also need for a grassroots driven Community Health Technical Working Group (CHTWG) to facilitate continuous collaboration between the communities and the county government. This CHTWG can also serve to support the processes by which Facility/Community Health Management Committees are identified, strengthened and subsequently utilized in holding the health facilities (public and private)accountable. On its part, the county government should be ready to incorporate the views of the community representatives, and stakeholders in the budgeting process so as to level their expectations and harness their resources.

4.2. Strengthening the Community Health Workforce

Community Health Workers are the epicenter of preventive health, and are critical for the uptake of essential clinical services. Within the informal settlements in Nairobi and Mombasa, the CHVs have an average workload of 100 households per CHV, against a desirable case load of 1CHV to 52 HHs. There is therefore a clear case for greater investment in the Community Health Workforce by the County governments. Beyond increasing the numbers and reducing their caseload, it is equally important to provide CHVs with basic functional training and kits, and to design a risk mitigation framework to secure the CHVs from contracting infectious diseases. An enhanced medical cover would go a long way in motivating the CHVs as the current allocation of KES 300,000 for NHIF cover for CHVs is too little. The presence of an

effective frontline health workforce would publicize government provided health services, address challenges of access and reduce reliance on private providers.

4.3. Investment in Routine Monitoring of Service Outlets

The commodity security technical working group and the County and Sub-County Health management teams need to be supported to conduct regular spot checks and to intensify backstopping to all health facilities. This has been documented to be one of the most effective ways of managing possibilities of pilferage of medicines at facility level. The presence of numerous unlicensed health service providers within the informal settlements is a risk to the populations and greatly compromises the attainment of the right to quality healthcare as provided for by Constitution and the Health Act, 2017. The capacity of the relevant county management teams to conduct routine spot checks should therefore be assessed, so gaps can be identified and solutions proposed.

4.4. Implementation and Monitoring of Kenya National Health Policy and the Kenya Health Act, 2017

To ensure the enjoyment of health as a Public Good in Urban Informal Settlements, the Kenya Health policy needs to be fully implemented. There's also needed to strengthen citizens role in holding government accountable for delivery of the same. Objective 4 of the Kenya Health Policy speaks to the provision of essential healthcare that is responsive to clients' needs. The Ministry of Health should therefore strive to develop solutions that are tailor made to address the unique complexities of vulnerable populations e.g. residents of informal settlements, taking recognition of what the economic vulnerability would call for, thus design of solutions that take these vulnerabilities into consideration. This would call for Innovative Pro-Poor Healthcare Financing and Delivery Models.

Additionally, The Kenya Health policy strives to strengthen the county and national planning and monitoring processes relating to healthcare provision, thus ensure that demand-driven priorities are efficiently and effectively implemented with priority policy strategies including the design, pilot and implementation of appropriate service delivery models for hard to reach areas and disadvantaged population groups In line with the provisions of public participation, citizens need to be equipped with the right information and tools to enable them to plug into policy discussions thus spell out their priorities, to inform investment in Healthcare. Citizens also have a responsibility to hold the National and County governments accountable and should thus take an active role in monitoring the delivery of this policy.

4.5. Inclusivity of marginalized groups for success of the Universal Health Care Agenda

The Government should provide platforms and mechanisms for Participation in planning for key healthcare agenda e.g. UHC implementation. This can be done through Public consultation forums; Thematic group meetings.; targeted focus group discussions and submissions of written memoranda. Deliberate efforts should therefore be made to consult, identify priority needs for marginalized groups and build them into the county annual work plans. Unless these marginalized groups are affirmatively targeted and fully involved in the Healthcare agenda, they stand to be overlooked in the broad socio-economic development of the country as whole.

4.6. Replication of Established Best Practices

There have been models of healthcare delivery such as those in Kakamega, Vihiga, Kitui and Makueni through which County governments (working with development partners) have successfully simulated health financing models to widen coverage and access to health services. These models have been used to target most vulnerable segments of population, and specific programs such as reproductive health/Maternal Neonatal and Child Health (MNCH). They could provide critical learnings in targeting populations in informal settlements, but any such intervention MUST be grounded in County legislation for sustained County financing/allocation of resources.

4.7. In the context of COVID -19…

The Ministry of Health through the Division of Community Health Services provides guidance to counties and stakeholders in the implementation of the community health strategy. Community health focusses on taking services closer to individuals, families and communities and increasing their participation in health. Strong community health structures are the foundation for disease prevention and health promotion and hence reduction in the burden of disease. As the country combats the COVID-19, community health structures will become critical in ensuring that all households are reached with correct information on COVID-19 as well as with prevention measures. Currently there are 6,335 community health units with 63,350 CHVs in Kenya, which is 67% coverage while there are just 1750 (18%) CHAs or CHOs supporting these units. These units in addition to engaging with other community groups including youth, men and women groups, faith sector, juakali sector will ensure that all community avenues are exhausted in reaching Kenyans with correct COVID-19 information and prevention measures and hence enable effective community participation in prevention of the local spread and transmission. The Community Health structures can play a critical role in behavior change and adoption of healthy habits at the households and community level by ensuring that correct information reaches the

households, demystify myths and misconception, demonstrate good hygiene practices including hand washing/hand rubbing, cough etiquette and reinforce messages passed through mass media. In the event that there is surge of cases, the community health volunteers can be trained and equipped with personal protective equipment and thermoguns so as to support active case finding in their community health units and linkages with county surveillance teams as well as monitoring and reporting on progress of cases on self - isolation in households. These proposed actions should therefore be packaged into Health Advocacy messaging by Civil Society Organizations.

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