Knowledge for Development and Diplomacy

Health equity and rights: research case study

Equity, health and wellbeing of people living and working in informal urban settlements



Slum in Nairobi, Kenya.
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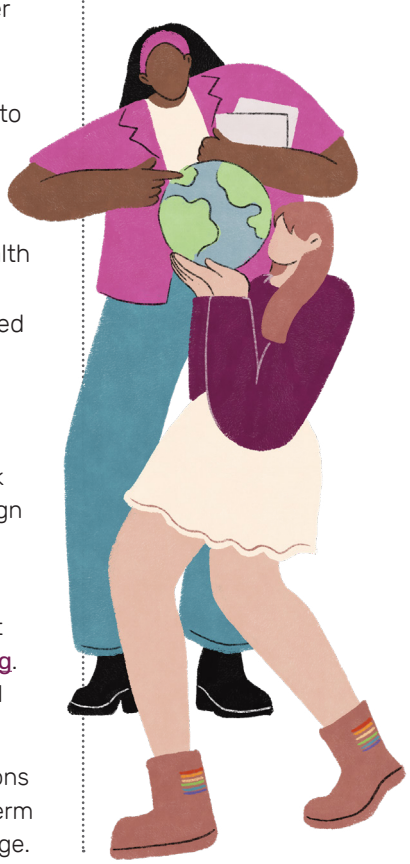
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Health is broader than disease and health equity begins outside the health sector. It is critical to understand that health is influenced by social factors such as environment, jobs, education, housing, food, water and sanitation. People with different social positions will have varying access to these resources, creating differences in exposure and vulnerability to health-compromising conditions. To address the root causes of health inequities we need to support interdisciplinary approaches which focus on social determinants of health, alongside attention to health services and interventions.

Informal urban settlements are an important context for understanding and addressing health inequities. Also known as slums, informal urban settlements vary in size and temporality and are expanding rapidly in the Global South. Many of the people living in these settings are vulnerable due to the interrelated challenges of poor health, limited access to basic services (e.g. water and sanitation) and health services, tenure insecurity, temporary and unpredictable work, and weak accountability mechanisms. However, populations living in informal settlements are not homogenous and some groups are more vulnerable than others – this can be hard to assess because there is little disaggregated data available and many people living in these settlements are undocumented and 'off the map'. This case study highlights learnings from research conducted across Kenya, Bangladesh, Sierra Leone and India as part of the ARISE consortium, which sought to enhance equity and accountability to improve the health and wellbeing of poor, marginalised people living in informal urban settlements. It focuses on research conducted in slums in Nairobi, Kenya to illustrate the strength in community-led approaches for supporting health equity.



Key learnings

- For equitable solutions, we need to recognise that communities are heterogenous and work closely with residents to identify those who are truly left behind and co-create and co-design research tools and interventions using participatory approaches.
- More social science research (i.e. qualitative, participatory, ethnographic research with an intersectional lens) is needed to understand communities' lived experiences of health, what equity means for them and the factors that adversely impact on their health and wellbeing. This needs to go beyond quantitative data (which is typically more attractive to funders and decision makers) and be conducted in partnership or led by the Global South.
- As far as possible, funding should be channelled to community organisations for interventions and should be as unrestrictive as possible. Health inequities are complex and so a longer-term approach should be taken to avoid small pilot projects that cannot achieve significant change.

Nairobi informal settlements case study

Nairobi typifies the rapid urbanisation and population explosion in sub-Saharan Africa. As the capital and largest city of Kenya, over 60% of residents are estimated to be living in slums and contributing to increasing urbanisation of poverty. This case study covers two informal settlements in Nairobi: Korogocho and Viwandani - densely populated settlements with high rates of poverty. In these slums, on average, a household has about three persons occupying one rentable room. The two sites are composed of webs of narrow footpaths, buzzing businesses, market stalls, street kitchens, managed public water points and multiple small churches and mosques. These slums are generally characterised by abject poverty, have open sewers, toxic air pollution, garbage dumps, overcrowding, insecurity, lack of access to water and adequate healthcare services as well as exposure to communicable diseases.

Despite investments over several decades, issues around health inequalities have not been resolved and in some cases have become worse. Examples of success have been large scale programmes tackling major social determinants (e.g. good roads have reduced the time taken to tackle fires) rather than small pilots. However, in these interventions it is often unclear how equity has been defined and what role communities play. Some interventions have created new inequalities, for example in some areas toilets have been built but residents are charged a fee to access them.

ARISE conducted research to identify who is vulnerable from the community's perspective, using their understanding and definition of 'vulnerable' or 'marginalised'. We used participatory action research cycles with identified vulnerable groups (the elderly, child-headed households, and people with disabilities) to document their lives and their day-to-day experiences and to understand how their vulnerability affects them. We used Photovoice, a creative participatory method where community participants use photography to gather information, stories, and personal experiences, to give participants a voice and the power to explain their strengths and challenges from their own perspective.

We found that key issues were similar across the three vulnerable groups, with some specific issues for each. Participants demonstrated how inequality is perpetuated by multiple different community members and systems across various social determinants of health. For example:

- People with disabilities with only one hand cannot be employed in the local factory even if they can perform certain tasks.
- While the government built roads in the slums, they left wide drains that the blind or physically disabled cannot jump over and could fall into.
- Child-headed households cannot access social protection programs including National Health Insurance Fund because they are not over 18 years.
- During Covid-19 the elderly struggled to access water from bowsers without assistance as they could not compete with younger people or stand in a queue.
- Lack of adequate nutrition was a major concern for all the groups – both getting enough food and the quality of food.
- Access to quality health services was limited for most groups due to the cost, distance and discrimination.

To begin addressing these issues, we set up a responsive fund (a small kitty for community organisations) which could be used on any interventions that helped to mitigate these challenges. Community organisations were shocked to learn of the inequalities within their own communities and came up with solutions which did not require a lot of resources. For example, community members lobbied local government leaders to address challenges related to solid waste management and channelled their own community resources; community organisations reached out to members of vulnerable populations who had never been reached before and linked them to existing government services; and child-headed households were identified and registered for National Health Insurance Fund and education support where possible.



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