Cardiovascular disease prevention in the slums of Kenya
van de Vijver, Steven
PART III

IMPLEMENTATION & EVALUATION
CHAPTER 9

Challenges of health programs in slums

Steven van de Vijver, Samuel Oti, Clement Oduor, Alex Ezeh, Joep Lange, Charles Agyemang, Catherine Kyobutungi

*The Lancet, accepted for publication*
ABSTRACT

Since 2007, the majority of the global population lives in urban settings. In regions like sub-Saharan Africa more than 60% of the urban population lives in slums—characterized by extreme poverty and poor health. Until now not much is documented on how to implement health programs in these dynamic and deprived settings and the challenges that one might encounter in the process.

The African Population and Health Research Center (APHRC) has more than ten years’ experience conducting research and implementing health programs in the slums of Nairobi. The aim of this paper is to share their experiences and provide some insights into the complexity around implementing health programs which may be useful for other actors interested in developing interventions to improve health and well-being in these neglected environments.

The key challenges for health programs in slum settings include insecurity, lack of infrastructure, high burden of disease, high population mobility, lack of social cohesion, political instability and interference, and attrition or dearth of human resources. These challenges are closely interlinked with poverty playing a central role. Some of the successful approaches we have used to mitigate these challenges include effective community sensitization throughout the project, recruiting staff from the target communities, use of local security structures, involvement of a diverse group of community leaders and stakeholders, community engagement based on values and principles that are consistently applied throughout the program, demonstrating the value of the institution to the community’s needs beyond a single project.

Slums are complex environments where residents have multiple competing priorities and therefore new programs and initiatives are not always perceived as being beneficial. On the other hand there is a strong need for improvement in health and quality of life in the slum population, so with the right approach implementation of health programs can be highly rewarding.
INTRODUCTION

The world is becoming increasingly urban. Of the projected increase of 1.9 billion in the world population by 2025, up to 95% will be urban dwellers [1]. Urbanization is mostly happening in low-income regions, with Africa having the highest rate of all continents [2]. Population growth rate in urban areas is almost double the rural rate, but more importantly, slum growth rate is higher than the overall urban rate [2]. This means that in the next few decades, the proportion of the urban population living in slums in sub-Saharan Africa might even get higher than the currently estimated 60% [2]. Overall, the number of slum dwellers in low and middle income countries is projected to double from one to two billion over the next thirty years [3].

The UN-Habitat has identified five characteristics that define a slum including inadequate access to safe water, inadequate access to sanitation and infrastructure, poor structural quality of housing, overcrowding and insecure residential status [3]. Governments, development partners, civil society and other stakeholders recognize the need to develop social programs that respond effectively to the needs of slum dwellers. However, there is limited evidence on how to best design and implement such programs in these deprived, often unpredictable and dynamic settings and what challenges one might encounter in the process [4-6].

The African Population and Health Research Center (APHRC) in collaboration with international partners have been working for the last decade in slum settings in Nairobi, Kenya conducting research and intervention projects [7-11]. The aim of this paper is to share our experiences and provide some insights into the complexities around designing and implementing programs aimed at improving health and wellbeing in such a dynamic setting.
KEY CHALLENGES IN WORKING IN THE SLUMS

In order to implement a health program in the slums it is important to acknowledge the complex and multifactorial impact of urban settings on health programming and outcomes. We describe the specific challenges of working in the slums, which can be placed within the conceptual framework on urban health [12] and relate to their impact on the delivery and intended outcome of health programs.

In the global and national political arena there is a significant gap between the rising awareness of the growth and importance of the slums and the lack of actual health generating policies, structures and interventions on the ground. The lack of structures and policies is not just in the area of health care but also in areas and sectors that have a direct and indirect bearing on the health of slum dwellers. These include urban planning and infrastructure, education, and employment, law enforcement and environment. This implies that health programs have to contend with other factors that have an impact on health but that may also disrupt the program, hence curtailing its impact. From time to time, higher-level politics at the level of national or municipal government may have significant impact on research and project work in the slums. For example, an attempt by the central government in collaboration with a UN agency to upgrade the road networks in a slum in Nairobi in the late 2000s led to demolishing of housing structures and displacement of residents some of whom had been recruited into various programs—and thus lost to follow-up.

With the near absence of public or state actors the private sector dominates the market in health care and other social sectors in slums [13]. These actors range from local traditional healers and quacks to well-established and structured local non-governmental, faith based organizations or other actors within the civil society. The latter are more likely to collaborate in research and health programs. Public-private partnership initiatives for health service delivery have been introduced in the slums to enhance access to and demand for quality healthcare services [14]. Health research and programs therefore have to engage with non-state actors for
greater impact and reach. Within the physical environment of the slums the main challenge for health programs is the high rate of crime [15]. Insecurity is also seen by the population as the major concern in daily life [16], and violence-related injuries contribute significantly to morbidity and mortality among the urban poor [17, 18]. Earlier research in the slums of Nairobi revealed that injuries ranked second to HIV/AIDS as a cause of death among individuals aged 5 years and above [15]. Depending on the location within the slum and the hour of the day, project workers are often exposed to high risk of crime. This is especially so, when they are seen or thought to be carrying expensive equipment such as laptops or PDAs. Insecurity also hinders residents from accessing services and/or limits the kind of the services they can access. The challenge of personal safety is not just due to crime but also due to the physical location of the slums. Slums are often situated in unsafe environments where flooding, landslides, industrial pollution, hazardous waste disposal and fire outbreaks are common partly due to the poor housing quality.

As most of the slums are unplanned settlements the infrastructure such as good road networks, water and sanitation systems in this area is limited and sometimes non-existent, which might complicate project activities during flooding or other natural catastrophes. Furthermore, communication infrastructure is generally lacking, leading to very limited connectivity and internet access, which further hinders project activities.

Another important challenge is keeping pace with the high mobility of slum residents. Besides people moving between the slum and their rural origins and sometimes staying there for extended periods of time, there is also a high mobility during the day. A lot of slum dwellers are informal daily laborers and have to look for an income, often outside their community. To increase their livelihood opportunities, they usually leave their household early in the morning and come back late in the evening. Because of this high level of urban-rural traffic, changing residences and daily wanderings, it is difficult to trace people during household visits and ensure reliable follow up of appointments.
Although unemployment is rampant in the slums it is difficult to find skilled staff due to non-availability of required expertise and unwillingness to work in slum settings. People who do not live in these areas are rarely willing to work there (mostly for security reasons) and those with the right skills are constantly on the lookout for opportunities that will enable them to move out of the slums. Long-term projects thus usually suffer from high turnover rates and need to constantly recruit and retrain staff.

One of the main barriers for slum dwellers towards empowerment and capacity to participate is poverty. The majority of the slum residents lives on less than one and half dollars a day, and has no stable sources of income which makes it very difficult to make ends meet (7). Health, and, specifically, prevention of disease, is often not a priority as people have to balance between meeting day-to-day basic needs and investing in behavior and practices that may generate longer-term returns. In addition 90% of the population do not have health insurance and have to rely on out-of-pocket payments for healthcare (16). This has a huge impact on the health seeking behavior.

Because of the nature and origin of slums, the social support networks are often fragile as there is great heterogeneity in the slum population (7). People from different parts of the country move to the city to make a living and in a relatively small and densely populated area there may be many different major ethnic groups with their own cultural norms and beliefs. In addition, there is a significant group that has come to the slums with traumatic past experiences which makes building trust a challenge (17). High levels of mobility, lack of community spaces to socialize, predominance of casual jobs with odd hours of work lead directly and indirectly to lack of social cohesion and most residents do not feel a sense of ownership or belonging in the community.

It is essential to involve the local community and its leaders in every project that is taking place in the urban informal settlements. However, the community leaders and the community in general tend to be somewhat suspicious of any new project or research activities and might even be reluctant to participate. On the
other hand, community leaders, once they realize the important position they occupy as custodians of the community interests, may exploit their positions and act as gate keepers.

Box 1: Example of multiple challenges
Isaac is a Community Health Worker in one of our health programs and is screening adults in the community for cardiovascular disease risk factors. As he had difficulties finding people at home during the day, he visited the household for another try at night. With the streetlight not functioning he had to wander in the dark when he was attacked by a criminal who matched his blood pressure monitoring machine possibly destined for the black market. The residents in neighboring structures did not respond to his cries for help as he was not recognized as a community member or CHW in this part of the slum.

Box 2: Recommendations to navigate through challenges in slum settlements for project success
1. Before the start of the project engage in effective sensitization that includes even those groups that may not directly benefit but which have the potential to threaten the implementation of the research/program.
2. Advertise jobs within the community but use well-structured competitive recruitment procedures as you should not leave these processes to the whims of the local leadership. You need to conduct due diligence before any individual is confirmed as part of the project team.
3. Use of local community security groups is in general sufficient to address threats within the same community. However, where external partners especially foreigners are involved, the use of formal and armed security agents is strongly advised.
4. Give priority to locals for staffing as this might benefit the project in several ways like access, acceptability, ownership, participation and indirect financial support of the neighborhood.
5. Obtain as diverse staffing as possible to ensure that various interests within the community are represented. This will ensure that cultural, religious and language barriers are broken.
6. Local politics may only be handled by constituting a formal diverse team of community leaders that represent all the various constituencies within the community. Depending on the duration of the program, the representatives might be rotated so as to avoid them developing a sense of self-importance that may work against the success of the project.
7. It is important that field staff is ready and committed to work outside conventional working hours, including weekends and public holidays in order to trace the highly mobile population in the slums.
8. To improve appeal and acceptability, engage with the community on general development activities that may not necessarily be directly related to the program they are working on like supporting sports, education or health activities.
CONCLUSIONS

The combination of high population density, poor living circumstances such as poor hygiene and limited health care access, makes the slum an important risk for the general public health. Therefore, the Post 2015 UN Development Agenda should address this under the priority to “leave no one behind”. Although there are important challenges for implementing health interventions in slum settings, it is essential to monitor and serve these populations. With more concerted efforts, the poor living conditions and their impact on health among slum dwellers can be improved (21).

By sharing the insights and experiences we hope to inform other actors and potential newcomers in this largely untapped field. Consequently, organizations can adapt and prepare their approach and activities which could lead to increased success and better health and social outcomes in the slums.

Conflicts of interest
SV, SO, CA, CK and JL received funding from the Academic Medical Center Foundation for medical research in the slums. APHRC receives core funding from the William and Flora Hewlett Foundation and the Swedish International Development Agency (SIDA). The funding sources had no role in the writing or submission of the paper.

Acknowledgments
We wish to acknowledge the fieldworkers of APHRC who have been working for the last ten years in these challenging surroundings, and Martin Njaga for his advice and edit on this paper.
REFERENCES


