Improving slum health: Current health service delivery models for the urban poor in Nairobi, Kenya

Introduction

In the race to sustainable development by nations, it is appreciated that no one should be left behind. In addition, universal health coverage is needed to ensure sustainable development. Rapid urbanization in Kenya, as elsewhere in sub-Saharan Africa, has resulted in growth of informal settlements, also known as slums, in urban centres, which are characterized by poverty, inadequate social services and poor health outcomes. Sixty percent of Nairobi's residents live in or under slum-like conditions. Assessing and documenting specific health and livelihood conditions experienced by residents of slum areas requires adequate data at local levels, often lacking through national surveys, which mostly provide national indicators that blur inter- and intra-sub-group inequities. Two decades ago, the African Population and Health Research Center (APHRC) put a spotlight on the plight of the urban poor in Nairobi, Kenya through the first Nairobi Cross-Sectional Slum Survey. Extreme poverty due to limited livelihood opportunities, limited access to quality essential preventive and curative services, poor environmental and sanitation conditions, poor access to basic amenities are the major underlying factors contributing to the high mortality in the informal settlements (APHRC, 2002). Critical and targeted investments were made resulting in some improvements in health and wellbeing outcomes (APHRC 2014). However, many residents are still unable to access adequate care when they need it and services available may be unresponsive to those needs. Understanding existing models of health services is vital to informing interventions that ensure access to quality and affordable care for all residents of slum areas.

Approach

Between 2017 and 2021, we conducted a mixed methods study to assess the healthcare service delivery in two urban informal settlements, Korogocho and Viwandani, in a bid to identify a viable model of service delivery that can be implemented in such populations. This was part of a larger study undertaken in Asia and Africa (Improving Health in Slums Collaborative, 2019).The study used a mixed methods design, employing geospatial mapping of all structures in the slums and characterization of mapped health facilities, qualitative interviews with various stakeholders and household surveys.

The Evidence

Mapping and health facility characterization

GIS mapping of formal and informal health service providers in the two sites resulted in mapping of 78 facilities in Viwandani and 53 facilities in Korogocho. These facilities included points of health service provision inclusive of chemists/pharmacies, public and private healthcare facilities, herbalists, traditional healers, faith healers.

These facilities were linked to the households showing their locations relative to the villages within the slums. Further, the facilities were characterized to assess their status in terms of equipment, services offered, list of essential medications, staffing levels, patients seen per day. (See figure 2)

Majority of public and private health facilities offered essential primary health at outpatient level including immunization services, Antenatal Care (ANC), minor injuries and other maternal and child health services. Many of the facilities open between 8am-5pm. Pharmacies on the other hand provide drug dispensation and in some cases provide consultation services and prescriptions.

Many of the health services provide free consultation in public health facilities but patients have to pay for treatment and medication. Private health facilities have consultation fee besides the treatment and medication fee.

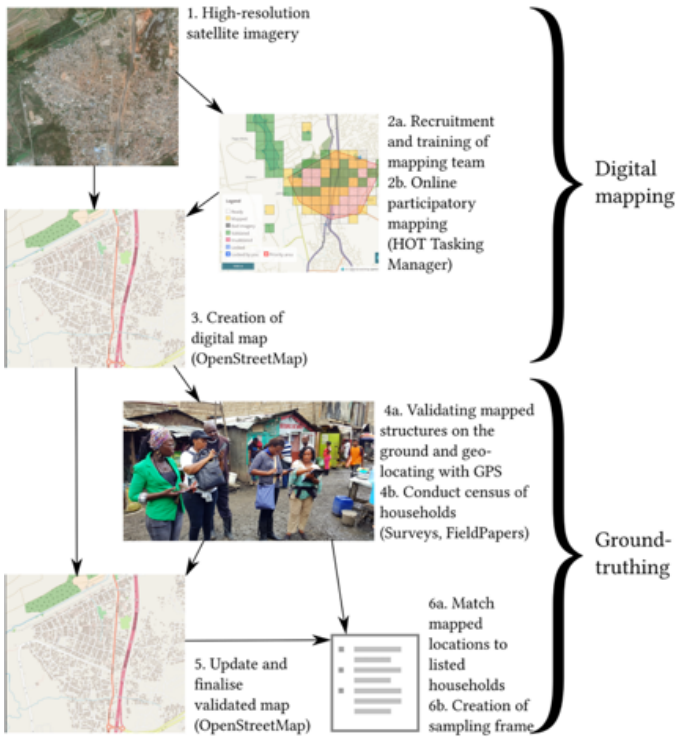

Figure 1 Flow of the mapping exercise (Bakibinga et al, 2019)

Household survey

Over 90% of the participants in both sites sought care one year preceding the survey. A higher proportion, 85% in Viwandani and 83% in Korogocho, of adults sought outpatient care. Among those who sought care 83% had acute conditions, 14% had chronic conditions while about 2% had both conditions.

More than half of the participants (52%) sought care in pharmacies while about 20% and 19% sought care in public or private health facilities respectively. Less than 2% sought healthcare from non-conventional care providers such as traditional healers, herbalists and faith healers.

There was a high utilization of care services reported in health facilities within and outside the slums. Slightly over 90% of the respondents reported that they were satisfied with the services. Out-of-pocket expenditure was the most common method of healthcare payment with an average payment of KES. 950 (USD 9.5) per visit. Insurance coverage was 27% among the respondents although with high variation in the two sites, 13% in Korogocho and 38% in Viwandani.

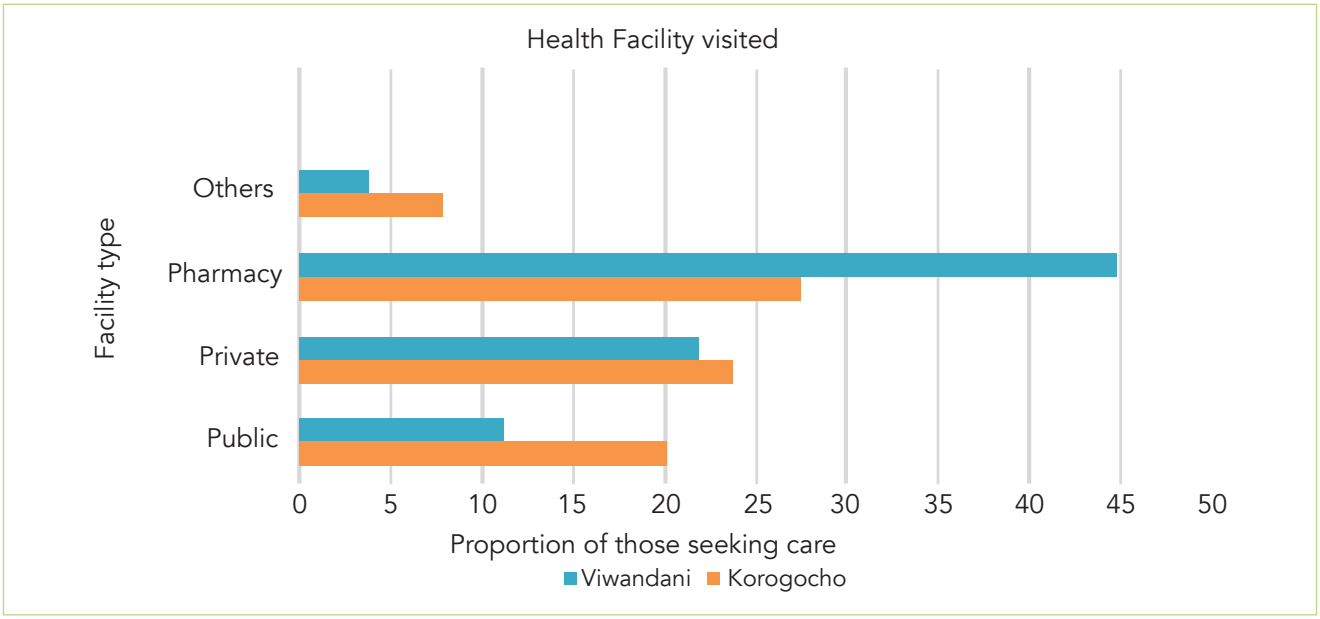

Figure 2 Proportion of healthcare facilities visited in the two sites

Stakeholder engagement

The community members reported that the formal services that they have readily available are immunisation, treatment of common illnesses, management of malnutrition and emergency response to outbreaks such as Cholera. However most allied and tertiary services such as laboratory, surgery, radiology, and certain drugs for chronic illnesses had to be sought from outside the slums.

> *Like for example when you get burned and you go to that hospital they will just do first aid to relieve the pain but they will refer you to another hospital for treatment" R2 FGD Men (18-24) Korogocho*

Some members of the population seek care from informal health providers such as faith and traditional healers.

> *There is a friend who had failed to get pregnant for a long time. She was told to drink those Maasai drugs; so I don't know if those drugs relaxed her muscles because she got pregnant in less than a month so she advises people to use Maasai drugs" R4 FGD Women (18-24) Korogocho*

> *Also one of my friends joined that church. Nowadays he does not believe in visiting a hospital because recently he was supposed to visit a hospital but he said that their pastor told them not to do so yet in the past he used to go to hospitals". R8 FGD (18-24) Viwandani.*

Challenges in accessing services

Several challenges were identified including; unconducive opening hours of the public health facilities, the lack of public health facilities and commodities, poor quality of health services, health workers' attitudes and lack of health insurance and the high cost of care.

> "I can say that people prefer to go to private hospitals because of the opening hours. You know at public hospitals they do not operate for 24 hours like private hospitals. So when you get sick at midnight, you can be taken to a private facility for medication". R8 FGD Women (25+) Korogocho

> "What I see is that most people prefer to go to public hospitals because charges are low although the challenge with public hospitals is that there have long queues and also being referred to other places to get laboratory tests" R7 FGD Men (25+) Viwandani

While some of the challenges were specific to the health sector, other concerns are related the slum environment and its lack of adequate essential amenities. Poor roads, insecurity and inadequate water, sanitation and hygiene services were highlighted as critical limiting factors to general health and wellbeing of the residents.

> "When it rains roads in Korogocho are very poor. On the part security when you go to the hospital it depends on the road that you use. because if you use the main road you will be safe but if you use paths which are deep in the village you will not be safe, so in Korogocho roads are good if it is not raining" R4 FGD Men (25+) Korogocho

> "What I would like to say is that the major challenge in our village is lack of toilets so the government should look at this problem and solve it and also they should construct roads." R1 FGD Men (25+) Viwandani

These challenges were further exacerbated by the Covid-19 pandemic. There was low healthcare seeking in health facilities compounded by fear in the community, disrupted supply of essential medicines and reallocation of resources to fight the pandemic (Kibe et al., 2020).

Recommendations for the improvement of health services

During the feedback sessions with community members, health providers and health managers, several recommendations were made;

- Suggestions were made to register all providers, including chemists and include them in stakeholder forums that would enable them to receive support from the public sector through supportive supervision activities. This would also be used to support improvement of clinicians' skills and attitudes.
- It was noted that there was a need to promote awareness on health behaviours and services amongst community members to enhance utilisation of formal health services.
- Although accountability mechanisms exist in the form of suggestion boxes, health facility charters, committees, and stakeholder forums, these services are limited to the public health facilities, which are very few. Extension of these mechanisms to the private healthcare providers was suggested, as they are responsible for the bulk of service provision in these communities. Furthermore, health managers requested support to be able to analyse and interpret the information that is collected in the different accountability portals.
- More engagements with decision makers were highlighted as necessary to ensure that more public services are made available in the communities. As despite awareness of the needs of community members, the health managers, were not able to respond to most of the issues.

Policy and practice implications

i. Given that some of the challenges to health access are beyond the health sector, collaborations with other sectors such as transport, WASH and education in interventions and operational research on social determinants of health are needed.

ii. Financial and social risk protection innovations are needed to promote community members' enrolment in health insurance schemes and reduce out of pocket expenditure on healthcare.

iii. Implementation research on improving quality of primary health care and linkages with allied and tertiary services is needed.

iv. There is need to empower lower level health managers to be more involved in policy and decision making processes. Approaches that are more bottom up than top-down are needed to reduce service delivery gaps in these communities.

v. Empowering communities to demand for accountability from leaders and service providers is necessary through the existing stakeholder forums and mechanisms such as health facility committees and suggestion boxes. In addition, these mechanisms need to be extended to private health facilities.

vi. Enhancing community members, health providers and managers' capacities to understand the value of information and its interpretation is necessary for better decision-making.

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