# Challenges of health programmes in slums

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## Introduction

The world is becoming increasingly urban. Of the projected increase of 1·1 billion in the world population between 2010 and 2025, virtually all will be urban dwellers.[1] Urbanisation is mostly happening in low-income regions, with Africa having the highest rate of all continents.[2] The population growth rate in urban areas is almost double the rural rate but, more importantly, the slum growth rate is higher than the overall urban rate.[2] In the next few decades, the proportion of the urban population living in slums in sub-Saharan Africa might therefore get even higher than the estimated 60% in 2010.[2] Overall, the number of slum dwellers in low-income and middle-income countries is projected to double from one to two billion during the next 30 years.[3]

The UN Human Settlements Programme has identified five characteristics that define a slum, namely 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 recognise the need to develop social programmes that respond effectively to the needs of slum dwellers. However, little evidence exists for how to best design and implement such programmes in these deprived, often unpredictable, and dynamic settings, and for what challenges one might encounter in the process.[4–6]

The African Population and Health Research Center, in collaboration with international partners, has been working for the past decade in slum settings in Nairobi, Kenya, doing research and intervention projects.[7–11] The aim of this Viewpoint is to share our experiences working in the centre and provide some insights into the complexities surrounding design and implementation of programmes aimed at improvement of health and wellbeing in such a dynamic setting.

## Key challenges for people working in slums

To implement a health programme in the slums, the complex and multifactorial effects of urban settings on health programming and outcomes need to be acknowledged. We describe the specific challenges facing people working in the slums, which can be placed within the conceptual framework for urban health[12] and relate to their effect on delivery and intended outcome of health programmes.

In the national and international political arena, a substantial gap exists between rising awareness of the growth and importance of slums and an absence of actual health-generating policies, structures, and interventions on the ground. This absence 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 areas include urban planning and infrastructure, education and employment, law enforcement, and the environment. This list implies that health programmes have to contend with other factors that have an effect on health but might also disrupt the programme, hence curtailing its effect. From time to time, high-level politics at the level of national or municipal government might have a substantial effect 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 demolition of housing structures and displacement of residents, some of whom had been recruited into various programmes and were thus lost to follow-up.[13]

With the near absence of public or state actors, the private sector dominates the market in health care and other social sectors in slums.[14] These actors range from local traditional healers and quacks to well established and structured local non-governmental, faith-based organisations or other actors within the civil society. Faith-based organisations are more likely to collaborate in research and health programmes. Public–private partnership initiatives for health service delivery have been introduced in the slums to increase access to and demand for quality health-care services.[15] Health research and programmes therefore have to engage with non-state actors for greater effect and reach. Within the physical environment of the slums, the main challenge for health programmes is the high amount of crime.[6] Insecurity is also seen by the population as the major concern in daily life,[16] and violence-related injuries contribute substantially to morbidity and mortality in the urban poor.[17,18] Early research in the slums of Nairobi[6] showed that injuries ranked second to HIV/AIDS as a cause of death in individuals aged 5 years and older. Depending on the location within the slum and the hour of the day, project workers are often exposed to a high risk of crime (panel 1). This risk is

> **Panel 1: One example of the many challenges**
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> Isaac is a community health worker in one of our health programmes and is screening adults in the community for cardiovascular disease risk factors. Because he had difficulties finding people at home during the day, he visited the household for another try at night. With the streetlights not functioning, he had to wander in the dark when he was attacked by a criminal who snatched his blood pressure-monitoring machine, possibly destined for the black market. The residents in neighbouring structures did not respond to his cries for help because he was not recognised as a community member or health worker in this part of the slum.

especially pertinent if they are seen or thought to be carrying expensive equipment such as laptops or personal digital assistants. Insecurity also hinders residents from accessing services or limits the kind of services that they can access. The challenge of personal safety is not just due to crime, but also 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 poor housing quality.

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

Another important challenge is to keep 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, the residents are also highly mobile during the day. Many slum dwellers are informal daily labourers and have to look for an income, often outside of 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, people can be difficult to trace during household visits and reliable follow-up of appointments can be difficult to ensure.

Although unemployment is rampant in the slums, skilled staff can be difficult to find because of non-availability of the necessary skills 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. Long-term projects thus usually suffer from high turnover rates and the need to constantly recruit and retrain staff.

One of the main barriers for slum dwellers to empowerment and capacity to participate is poverty. Most slum residents live on less than US$1·5 per day and have no stable sources of income, which poses great difficulty in making ends meet.[6] Health and specifically prevention of disease is often not a priority because people have to balance meeting of day-to-day basic needs with investment in behaviour and practices that could generate long-term returns. Additionally, 90% of the population in Nairobi's slums, for example, do not have health insurance and have to rely on out-of-pocket payments for health care.[16] This factor has a huge effect on health-care seeking behaviour.

Because of the nature and origin of slums, social support networks are often fragile because the slum population is greatly heterogeneous.[6] People from different parts of the country move to the city to make a living, and in a small and densely populated area, many different major ethnic groups might coexist, with their own cultural norms and beliefs. Additionally, many have come to the slums with traumatic past experiences, which makes building of trust a challenge.[17] High levels of mobility, an absence of community spaces to socialise, and a predominance of casual jobs with odd hours of work lead directly and indirectly to an absence of social cohesion, and most residents do not feel a sense of ownership of or belonging to the community.

The local community and its leaders should be involved in every project that is taking place in the urban informal settlements (panel 2). However, 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 realise the important position that they occupy as custodians of the community interests, might exploit their positions and act as gatekeepers.

## Conclusion

The combination of high population density and poor living circumstances, such as poor hygiene and restricted health-care access, makes slums an important risk for general public health. Therefore, the post-2015

UN Development Agenda[19] should address this issue under the priority to "leave no one behind". Although important challenges exist for implementation of health interventions in slum settings, these populations need to be monitored and served. With concerted efforts, poor living conditions and their effect on the health of slum dwellers can be improved.

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

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