Cash flow within society: Given the high poverty levels found within the catchment areas of the health facilities visited, nutrition commodities are sometimes sold, and often shared with other household members. There is limited ability to purchase nutritious foods for children exposing them to poor nutrition and common infections.

Acceptability - Supply-side

Staff interpersonal skills including trust: Many of the staff observed had good interpersonal skills and were actively engaging both caretaker and child. Often this was witnessed with the CHEWs and CHVs and less with the other cadres. As noted by caretakers:

Acceptability - Demand-side

Household expectations: Caretaker expectations have been "conditioned" to the availability of services. While they may not be informed of official working hours, many caretakers are aware of operational practices and conform to these as much as possible. This means, invariably, that some caretakers and their children, cannot attend for MCH services or do so with significant opportunity costs, including foregoing income – and the ability to buy food - for that day. This is extremely difficult for many caretakers who live on day- to-day subsistence.

Low self-esteem and lack of assertiveness: Caretakers, particularly young women, new migrants and minority groups, including people with disability, may lack the confidence to negotiate the complexity of health service organisation and procedural requirements. This suggests that greater voice and accountability are required to ensure a more people-centred service.

Community and cultural preferences: There was widespread reference to cultural practices, reflecting the diversity of the population in the informal settlements – these range from those who will not seek services due to religious or cultural beliefs (and choose to use traditional birth attendants and healers in lieu) as well as those who restrict the diets of children and mothers. Poor feeding practices are passed along generations, from grandmother, to mother, to daughter. The diversity of cultural and community preferences reinforces the need for contextualised, client- focused IYCF counselling and education.

Stigma: Fear and stigma associated with malnutrition was mentioned in only a few instances while the fear of HIV testing for the mothers during ANC was cited as a reason for not attending formal services but only in a few instances.

Lack of health awareness: CUs, when functional, are a powerful tool for community engagement and sensitization. However, most caretakers and some health workers acknowledged that the CUs were not active, creating challenges for defaulter tracing and community sensitisation. An area noted where intensified health awareness is required is the utilisation of Baby Well Clinic services after the baby's ninth month as thereafter most children do not attend unless they fall ill. This is a missed opportunity for promoting optimal IYCF during the entire 1,000 day period.

Conclusion and Recommendations

As evidenced from Nairobi[2], and other rapidly urbanizing contexts, the health risks of unplanned urbanisation are disproportionately shouldered by the urban poor. Given that the large majority of informal settlement dwellers are involved in income generation activities during daytime hours, important attributes of health service delivery in poor urban settlements are the days and hours of service[3]. It is further noted in the health seeking behaviour literature that, "…it is often the system itself which serves to limit an individual's capacity to engage with it"[4]. Recommendations for consideration by the County and Sub-County Health Management Teams include the following:

Operating hours: Whilst the Government of Kenya civil service handbook states that the official working hours are Monday to Friday from 8 am to 5 pm with one hour for lunch, the window for accessing health services in the majority of facilities visited is much shorter than this. Clients have been conditioned to attend en masse with resultant long queues for MCH services. It is therefore recommended that health facilities are "reconditioned" to provide services in a timely manner starting at 8 am and continuing through to 5 pm. This would need to be done in conjunction with community sensitization so that caretakers are made aware of the longer hours and can plan accordingly. It is further recommended to trial Saturday morning MCH clinic hours in selected high volume facilities. This does not require a policy change, as some health workers have alluded, but rather management intervention.

Service reorientation and integration: As recommended by some Sub-County Medical Officers, nutrition should be a "whole site" effort, reinforced at all service contact points with referrals managed in a timely manner for those requiring treatment. This would serve to reorient health services to the promotion of good nutrition, from their current orientation of treating malnutrition (i.e. a curative focus). This would imply that health workers have the requisite skills to provide nutrition information and counselling, tailored to the needs of the client. Reconfiguration of MCH services is also recommended so that caretakers, and their children, do not have to queue for each MCH service but, rather, can access a constellation of related services as a form of "one stop shop". This would serve to reduce waiting times and improve client experience; furthermore, while services are delivered on a first come, first serve basis, it is recommended that severely ill children are given priority. Greater integration could also extend to the private sector, given their proliferation in informal settlements, as sites for promoting good nutrition and referring children who require treatment services.

Client voice and accountability: Caretakers welcomed the opportunity to be heard and to voice their views, both positive and negative, about their client experience. This form of feedback, if captured in real time and fed back into the health system has the potential to improve the responsiveness of service delivery. Positive feedback should be recognised and rewarded (where feasible) while remedial measures should be taken to address sub-optimal performance. This should look at both facility as well as individual performance. The review uncovered outstanding performance – recognised as such by caretakers – but "invisible" in the health system. Greater understanding of what motivates and drives high performance should be sought so that these behaviours can be emulated.

Community engagement: Greater awareness, sensitization and linkages with the community is also required. This presupposes functional community units and well as greater multi-sectoral engagement – with specific attention to employers as well as the day cares that women rely upon to participate in the labour market. A critical factor to community engagement is (CHV) motivation and incentives. In all health facilities, attrition of CHVs was extremely high, a lost resource to the community and health system. To redress this, introducing a basic stipend for the most active CHVs and ensuring that this group have adequate capacity and support to promote maternal, infant and young child nutrition is suggested. In addition, sensitization of employers on health rights and access to health services should also be prioritized. Again, positive employer behaviours (e.g. those employers allowing caretakers to attend MCH services with pay) should be identified and recognised so that they can be emulated in the sector. Greater engagement would facilitate improved health seeking behaviours and prevention by addressing some of the underlying causes of malnutrition in urban informal settlements.

2 Zulu EM, Beguy D, Ezeh AC et al. 2011. Overview of migration, poverty and health dynamics in Nairobi City's slum settlements. Journal of Urban Health, Bulletin of the New York Academy of Medicine 88: 185–99.
3 Adams, A., Islan, R. and T. Ahmed, 2015. Who serves the urban poor? A geospatial and descriptive analysis of health services in slum settlements in Dhaka, Bangladesh. Health Policy and Planning 2015;30:i32–i45 doi:10.1093/heapol/czu094.
4 Sara MacKian. A review of health seeking behaviour: problems and prospects, DFID Health Systems Development Programme, HSD/WP/05/03.

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Education

"Health education needs to be contextualised to the caretaker's situation, it is not a conversation that you can have in five minutes". Sub-County Medical Officer

Opportunity costs

In most instances, time taken to attend the MCH clinic, is done at the expense of an income for that day or the needs of the household, including other children.

Staff interpersonal skills

"The health workers are friendly, knowledgeable but very slow" (Mother, Bahati Health Centre).

"…the health workers are very nice to us, especially the nutritionist. She counsels the mothers very well on importance of exclusive breastfeeding and proper feeding practices" (Mother, Kahawa West Health Centre).

Low self-esteem and lack of assertiveness

"Mothers who lack a voice or are unable to negotiate are turned away". Mother, Health Centre in Ruaraka Sub-County

Community and cultural practices

"[The] daughter was told by mother that salt should not be added to the baby's food. Baby should only be fed on mashed bananas and pumpkin. Baby should not eat onions and fried foods. So, what is the source of iodine for this baby? What about other essential micro nutrients?" (Health Worker, Bahati Health Centre).

Lack of health awareness

Where the community health strategy is operating, it has "changed so many things in the health centre. Men are now coming with their wives". (Health Worker, Huruma Lions Health Centre).

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Maternal and Child Health Services

Why Do Caregivers not Attend?

A Review of Barriers to the Utilisation of MCH in Nairobi Informal Settlements

MCH Services:
why do caregivers not attend?

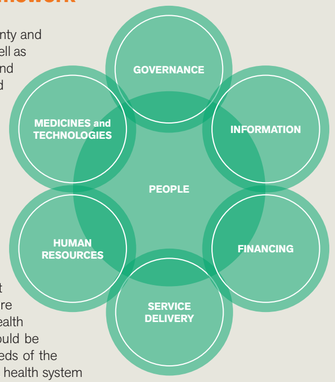
A REVIEW OF BARRIERS TO THE UTILISATION OF MATERNAL AND CHILD HEALTH SERVICES IN NAIROBI INFORMAL SETTLEMENTS

Introduction

This review was commissioned by Concern Worldwide, in collaboration with Nairobi County and Sub-County Health Management Teams, and supported financially by UNICEF Kenya. The review was prompted by concerns over the low coverage of nutrition services – specifically integrated management of acute malnutrition (IMAM) - in Nairobi's informal settlements. Coverage assessment reports for Nairobi repeatedly attribute low utilization to, among other factors, competing tasks of caregivers. Access to health and nutrition services is a challenge since very few public health providers serve informal settlements. Those that do, lack client oriented services to suit the circumstances of informal settlement dwellers. County and Sub-County Health Management Teams therefore requested an in-depth review to identify barriers to the utilisation of maternal and child health (MCH) services.

Methodology and Analytical Framework

The review entailed key informant interviews with County and Sub-County Health Management Team members as well as health workers and caretakers in high volume public and faith-based organisation (FBO) MCH clinics, located within and on the periphery of informal settlements in eight sub counties: Kamukunji, Westlands, Dagoreti, Embakasi, Makadara, Kasarani, Starehe and Ruaraka. In total 21 health facilities were visited and 28 and 25 health workers and caretakers interviewed respectively. The site visits were conducted in the month of July, 2015 by the author and two research assistants.



The review employed the WHO health system framework (Figure 1).[1] A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. People feature at the centre of the WHO framework, a reminder that health systems – and their constituent building blocks – should be people-centred, designed to be responsive to the needs of the communities they serve. This broad interpretation of a health system has been employed for this review.

To understand the myriad barriers that exist in accessing health services, an analytical framework was employed. This framework recognises that barriers exist and interact on both the supply and demand side. Demand-side determinants are factors influencing the ability to use health services at individual, household or community level, while supply-side determinants are aspects inherent to the health system that hinder service uptake by individuals, households or the community. Barriers included geographical access; availability; affordability; and acceptability.

Findings

Findings were arranged by barrier as well as their supply- and demand-side orientation based on the analytical framework. The most critical of these have been highlighted.

1 World Health Organisation (2007) Everybody's Business: strengthening health systems to improve health outcomes (WHO's Framework for Action), WHO, Geneva.

Accessibility – supply side

Service location: The majority of public health facilities visited are situated on the periphery of the informal settlements while FBO clinics visited are situated within. Irrespective of location, the pattern of service utilisation in many of the health facilities is erratic, with one health facility serving women from the immediate as well as distant communities. There is a perception by health workers and managers that utilisation, and the decision to seek services from one facility over another, is based on the reputation of the facility. "Erratic" utilisation as well as in- and out-migration patterns within informal settlements, create challenges for follow up, defaulter tracing, as well as health service organisation.

Accessibility – demand side

Indirect costs to households: Costs of transportation were not cited by caretakers attending the MCH clinic, however it can be assumed that this is a factor for those that do not attend. Means of transportation was not cited as an issue although it was reported by health workers that attendance at the MCH clinic is seasonally effected. In particular, attendance is lower in the rainy season when the roads in the informal settlements become quagmir es, making movement difficult.

Availability - Supply-side

Unqualified health workers, staff absenteeism, and opening hours: There is a shortage of nutritionists within the health facilities visited. The fall-back position is to use Community Health Extension Worker as "declared" nutritionists; this tactic also extends to Community Health Volunteers. It was observed that, in many instances, CHVs, CHEWs and students were providing IMAM and growth monitoring promotion (GMP) services. While some have received training, others have learned on-the-job. Staff absenteeism was also an issue in some of the health facilities visited. This practice was more in relation to late arrival than complete absence. In some of the health facilities visited, it was observed that there was a relaxed practice in relation to the opening hours in some health facilities while the practice of limited MCH operating hours was found to be more prevalent. When asked if extended hours would improve service utilisation, including opening the MCH clinic on Saturday mornings, many health workers and caretakers considered that this would be beneficial.

Waiting times: As many MCH clinics operate in "bursts of energy" for just a few hours in the day, this pattern ensures lengthy queues and long waiting times before caretakers and their children are attended to. In a FBO Health Centre, the caretaker had been waiting five hours with a child with a fever to see the doctor and was still not attended at the time of interview while in a Health Centre in Embakasi Sub-County, the caretaker interviewed had also been waiting five hours. She indicated that she often comes at 6 am as the queue is very long. Other facilities had shorter waiting periods however in almost all facilities, long queues are the norm. If a child requires multiple services, there is a separate queue for each service compounding the waiting time.

Motivation of staff: Some health workers were motivated, passionate even, in counseling mothers on nutrition issues, in particular exclusive breast feeding and complementary feeding. The presence of motivated staff was one reason that woman chose one health facility over another. However, while some health workers offer good service others are felt to be abusive or dismissive. In many instances it was also reported that the majority of CHVs were also not motivated; however those met as part of the review were part of the minority.

Opening hours

"The mothers are expected to report to the health facility by 8.00 am but they begin to be served at 10.00 am. Yet any mothers arriving after 10.00 am are not registered and attended to…" Father, Health Centre in Kamukunji Sub-County.

"Today I had to take an unpaid day off from my place of work to bring baby to the baby well clinic. If they were open on Saturdays, I would have preferred to come then, but they are not open. And yet I need someone to advise me on how to introduce other foods to the baby" (Mother, Health Centre in Embakasi Sub-County).

Waiting times

"It's on a first come, first served basis. Today I have been here since 8.30 am. My baby has been weighed but I am still waiting for the immunization" (Mother, Health Centre in Makadara Sub- County, time 12:23 pm).

Motivation of staff

"The day I miss the lady [the nutritionist], I'm sincerely hurt". Mother, Kayole 2 Health Centre

Drugs and other consumables

"If a mother comes to the health facility, one to two times and meets there is no Plumpy Nut, she does not come back again" (Health Worker, Health Centre in Dagoreti Sub-County).

"I tell the mothers that these commodities [Plumy Nut and Plumpy Sup] will not always be available and that it is up to them to feed their children well" (Health Worker, Kayole 2 Health Centre).

Non-integration of health services

"Nutrition services [are treated] as a 'by the way'" (Sub-County Medical Officer).

Drugs and other consumables: Reportedly, IMAM commodities are a major issue in all health facilities visited with stock outs of Plumpy-Nut and Plumy-Sup common for significant periods of time (reported to range from 1-6 months). This contributes to the low utilisation of services. Ironically, stock outs may encourage better communication with mothers as health workers seek to fill the commodity gap with promotive and preventive measures.

Non-integration of health services: There was little mention of the lack of integration of health services by health workers or caretakers however Sub-County Medical Officers consulted highlighted this as a critical issue. It was noted that vertical programme approaches resulted in missed opportunities and a lack of "accountability to the child". Another Sub-County Medical Officer indicated that a "whole of facility" approach to promoting good nutrition was required.

Lack of opportunity (exclusion from services): A whole of facility approach to the promotion of nutrition would reduce exclusion from nutrition services. It was noted that, in some facilities, even antenatal care (ANC) clients and those with babies at six months beginning complementary feeding, were not counselled unless a CHV or CHEW intervened.

Late or no referral: Referrals do occur, from the community to health facilities and from other departments within health facilities however this practice is not systemic. In almost all instances, health facility personnel did not report the presence of an active community unit (CU), limiting referrals from communities to health facilities or follow up in communities. Furthermore, despite widespread recognition of informal day care centres as a "source" of malnutrition, there is no sustained engagement with these sites by health facilities or CUs. As mothers work long hours, this means their children go for significant periods without adequate care or food. The lack of referral or engagement with day cares is a significant missed opportunity for addressing malnutrition within the community.

Availability - Demand-side

Information on health care services, providers: The lack of functionality of CUs as well as the infrequency of community outreach has a significant bearing on utilisation of MCH services. Word of mouth however does play a role in where caretakers decide to seek services with some facilities, such as German Baraka, having a virtuous reputation while others are considered not to be service-oriented. While most facilities visited were busy this should not be taken as an indicator of good performance.

Education: It is recognised that caretaker education levels have a direct bearing on child nutrition status. These were not established as part of the caretaker interviews however it was noted that many of the mothers that were interviewed were young, often with their first child. They were in search of Infant and Young Child Feeding education and were motivated to attend MCH services to ensure that their child was thriving. Health workers interviewed acknowledged that many mothers lacked knowledge on feeding practices, contributing to sub optimal IYCF.

Affordability - Supply-side

Costs and prices of services, including informal payments: As services are free in the public health facilities and the cost minimal in FBO/NGO supported clinics, this was not noted as a barrier to utilisation. Additionally, informal payments were also not mentioned.

Private-public dual practices: Dual practice was not reported during the field work although it is understood that the practice exists. There appears to be very little engagement with private practices.

Affordability - Demand-side

Household resources and willingness to pay: The health facilities selected for this review all serve informal settlements. In these settlements, household resources are extremely limited and poverty is often cited as a reason for poor nutritional status. This also contributes to poor caring practices particularly when mothers are required to leave their children for significant periods of time, often in the hands of informal day care centres. As services are free in the public health facilities and highly subsidized in FBO facilities, willingness-to-pay was not cited as a barrier.

Opportunity costs: Opportunity costs are a significant barrier to the utilisation of MCH services. Most women who attend the MCH clinics work, whether this is through casual, self-employed or formal employment arrangements. Some employers respect health rights and allow caretakers time off to attend MCH clinics, provided they can demonstrate attendance, but this was mentioned rarely.