Social Science & Medicine 110 (2014) 1–9

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

A qualitative exploration of access to urban migrant healthcare in Nairobi, Kenya

Christine Arnold [a], Jason Theede [b], Anita Gagnon [a,*]

[a] McGill University, Canada
[b] International Organization for Migration, Switzerland

ARTICLE INFO

Article history:
Received 14 May 2013
Received in revised form
20 February 2014
Accepted 20 March 2014
Available online 21 March 2014

Keywords:
Kenya
Nairobi
Migrant
Migration
Urban
Healthcare
Access

ABSTRACT

In recent years, Kenya's capital city Nairobi has experienced an influx of international economic migrants, as well as migrants forced to flee their neighboring countries of origin, or coming from UNHCR-managed refugee camps into the city. Urban migrants regularly face challenges integrating with host communities and consequently face health vulnerabilities. The International Organization for Migration in Kenya was concerned about the potential marginalization of urban migrants from mainstream health programming and a lack of data upon which to base their activities. The purpose of this project was to gain a greater understanding of urban migrants' barriers to accessing healthcare in Nairobi compared with barriers faced by Kenyans living in the same locations. Guiding our work was a conceptual framework for assessing access to healthcare, which defines availability, geographic accessibility, financial accessibility and acceptability as the four dimensions of access. We identified key informants in collaboration with The National Organisation for Peer Educators, and these individuals assisted in identifying communities within Nairobi where large proportions of migrants reside. Four communities were selected for further study. In each, interviews with government officials and service providers were conducted, and focus group discussions were held with both migrants and Kenyans. Verbatim transcripts were content-analyzed using an open coding technique. Common barriers to accessing care that were shared by migrants and Kenyans included waiting times, drug availability, transportation and cost. Barriers unique to migrants were: threat of harassment; cost discrepancies between migrant and Kenyan clients; real or perceived discrimination; documentation requirements and language barriers. Despite articles from the 2010 Constitution of Kenya that assert the right to health for every person in Kenya, migrants continue to experience unique barriers in accessing healthcare. Efforts to eliminate these barriers should address policy-level interventions, strengthened networks and partnerships, improved migrant-sensitive services and especially continued research in migrant health.

1. Background

Due in part to its relative political and economic stability, Kenya has for decades been a popular destination for migrants fleeing the humanitarian crises of neighboring countries, and has become one of the largest refugee-hosting countries in the world. Refugees and asylum-seekers are increasingly leaving the overcrowded refugee camps in northern Kenya to settle in the capital city, Nairobi (Campbell, 2006; Pavanello et al., 2010). Furthermore, Nairobi is the economic hub of East Africa and is rapidly attracting 'economic migrants' to the city. Economic migrants are those *leaving their habitual place of residence to settle outside their country of origin in order to improve their quality of life* (IOM, 2011e, p. 32). They may migrate through official or unofficial means, and therefore economic migrants may also comprise irregular migrants (IOM, 2011e). An irregular migrant is "*a person who, owing to unauthorized entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in a transit or host country. The definition covers inter alia those persons who have entered a transit or host country lawfully but have stayed for a longer period than authorized or subsequently taken up unauthorized employment*" (IOM, 2011e, p. 54). For the purpose of this project, we consider the term *migrant* to include irregular and regular migrants, as well as refugees and asylum-seekers. We do not, however, focus on internal migrants.

* Corresponding author. Nursing Research, McGill University Health Centre, 2155 Guy St. #400-09, Montreal, Quebec, Canada H3H 2R9.
E-mail address: anita.gagnon@mcgill.ca (A. Gagnon).
URL: http://migrationandreproductivehealth.org/

http://dx.doi.org/10.1016/j.socscimed.2014.03.019
0277-9536/

Urban migration and its impacts on population health have been increasingly studied in recent years. The majority of studies have focused on the health of individuals who migrated from rural to urban areas within a single country (internal migrants), or the healthcare experiences of international migrants who have resettled to Western countries (Gagnon et al., 2009; Harpham, 2009; Merry et al., 2011; Ruiz-Casares et al., 2010). To our knowledge, the number of studies that address urban migrant health in low- and middle-income countries is limited. Those that do exist predominantly address macro-level analyses of problems associated with irregular migrants' access to essential services, without an examination of the challenges faced by migrants at the ground-level, and therefore have limited implications for how to develop interventions (Ruiz-Casares et al., 2010). With an estimated 80% of refugees being hosted by low-income countries (UNHCR, 2011), and a simultaneous trend toward urbanization, the experiences of urban migrants in low-income countries is an understudied, timely and significant area of focus.

1.1. Migration health in Nairobi

The International Organization for Migration (IOM) contends that migration itself is a determinant of health for migrants because it fuels inequities that cross-cut biologic, lifestyle, community, employment, socioeconomic, cultural and environmental factors (IOM, 2011b). By virtue of enduring circumstances that cause migrants to leave a place of residence, combined with the upheaval of their livelihoods and social support networks, and unforeseen difficulties integrating into new environments, migrants encounter unique health vulnerabilities (Carballo and Nerukar, 2001; IOM, 2011c). The consequences of such vulnerabilities are not experienced by migrants alone, but also by the communities with which they interact. Consequently, IOM employs an approach to migration health that is "based on an understanding that health vulnerability stems not only from the individual but also a range of environmental factors specific to the unique conditions of a location, including the relationship dynamics among mobile and sedentary populations (IOM, 2011f)." These "spaces of vulnerability" are locations where the health of both the migrant and sedentary or host populations may be at risk. Spaces of vulnerability may include "areas where migrants live, work, pass through or originate from" such as border posts, truck stops, and urban informal settlements, among others (IOM, 2011d).

Borrowing from this approach, we consider Nairobi's informal settlements to be spaces of vulnerability due to the fact that they are densely populated areas likely to attract migrants as a result of social ties, low cost of living, and for irregular migrants, the ability to remain uninterrupted by authorities (IOM, 2011c; Pavanello et al., 2010). We therefore wish to address migrant health in Nairobi's informal settlements by using a spaces of vulnerability approach, which will explore disparities in health not only among migrants but also within the communities they live.

Although there is evidence that urban migrants in Eastleigh, Nairobi fare worse than their Kenyan neighbors on several indicators, including infectious disease rates, maternal child health outcomes and psychosocial well-being (IOM, 2011b; Mapendo International, 2010), no such data are available on the health of migrants living in informal settlements outside of Eastleigh. We therefore chose to focus our investigation outside of Eastleigh, since we sought to identify and understand the needs of less visible migrant communities, since access to healthcare services (specifically maternal-child services) has previously been studied there, and because there is already increasing attention to the Somali community in Eastleigh.

We hypothesize that barriers in healthcare access could be contributing to health disparities among individuals living within the previously described spaces of vulnerability, and that migrants experience unique barriers in gaining healthcare access. Guiding our project is the conceptual framework for assessing access to health services proposed by Peters et al. (2008), which describes four main dimensions that influence access and contribute to the quality of healthcare services: (1) availability; (2) geographic accessibility; (3) financial accessibility and (4) acceptability. In their research, Peters et al. (2008) found that the poor and other vulnerable populations in low- and middle-income countries are consistently at a disadvantage in each dimension of access, and that any given dimension may be the most important factor at any particular time and place, depending on the specific context. The framework enabled us to design the project to explore and address the specific barriers related to each of the broader dimensions.

1.2. Overview of relevant migrant health policy in Kenya

The 2010 Constitution of Kenya states that a fundamental duty of the State is to fulfill the rights of every person in Kenya, including the right to the highest attainable standard of health (The Constitution of Kenya (2010)). As a signatory to The International Covenant on Economic, Social and Cultural Rights (2000), Kenya has committed to the "progressive realization" of this standard. In addition, as a signatory to the 1951 United Nations Convention and 1967 Protocol relating to the Status of Refugees, as well as the 1969 Organization of African Union Convention, Kenya has a duty to offer protection to refugees and asylum-seekers. Further, resolution 61.17 on the health of migrants by the World Health Organization (to which Kenya is a member state) called upon its members to "recognize the health of migrant populations as a human right" through four major pillars: policy and legal frameworks, improved migrant-sensitive health systems, monitoring of migrant health and strengthened networks and partnerships (WHO, 2010). The Kenya Ministry of Public Health and Sanitation, in collaboration with IOM and the World Health Organization (WHO) acted on the WHO 61.17 resolution by organizing a *National Consultation on Migration Health*. In line with the Kenya National Health Sector Strategic Plan II which lists "increase equitable access to health services" as its first policy objective (Ministry of Health, 2005), the 2011 National Consultation drew various stakeholders together who formulated a common action plan for providing accessible, affordable and non-discriminatory healthcare to all people in Kenya (IOM, 2011b; Ministry of Health, 2005). As a result, individuals should be able to access healthcare services irrespective of their immigration status, and any identified barriers that prevent them from doing so should be a priority area of concern of policymakers and stakeholders in public and migrant health.

1.3. Overview of the healthcare system in Kenya

The public (government-run) healthcare system in Kenya is administered by the Ministry of Health which is comprised of the Ministry of Public Health and Sanitation and the Ministry of Health Services. Service delivery involves a multi-level system, with public clinics as the most common point-of-entry. Users should be able to access services provided at the public clinics (e.g. laboratory, TB screening and treatment, voluntary counseling and testing for HIV, HIV comprehensive care, antenatal care, immunizations and family planning services) for a registration fee of 20 Kenyan shillings (Mapendo International, 2010; Turin, 2010). If further treatment is required, users will be referred to secondary or tertiary facilities, and will be charged a fee for additional services (Mapendo International, 2010).