

A STUDY ON  
**HEALTH VULNERABILITIES  
OF URBAN MIGRANTS IN  
THE GREATER NAIROBI**





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IOM International Organization for Migration

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## FOREWORD

According to the 2009 Revision of World Urbanization Prospect Report 50 per cent of the global population lives in urban settings, as Africa continues to develop, more and more migrants are finding their way into the urban centres in search of better economic opportunities. The traditional view of asylum seekers and refugees living in refugee camps in Africa only tells part of the story. Many migrants, including asylum seekers and refugees, reside in informal settlements, where limited health and financial struggle to accommodate the growing population. Migrants are thus faced with a series of vulnerabilities including increased risk to poor health and living conditions that is further exacerbated by a lack of targeted health promotion documentation, low levels of education, crowded household and competition for scarce resources.

IOM along with UN organizations and civil society organizations have been supporting advocacy and service delivery to urban migrants. However, these activities have been limited by poor understanding of the vulnerabilities urban migrants face. This report seeks to broaden our understanding of migrants residing in selected locations of Nairobi city, and the challenges they face in accessing health services. The report documents information from stakeholders, including health care workers, migrants, community leaders, and government representatives on migrants' access to health services. Gaps were identified in order to design interventions that will increase and improve the accessibility and acceptability of urban migrants to health care.

On a positive note, the report highlights the willingness by health care providers and government representatives to respond to the health needs of migrants. Interestingly, migrants along with Kenyan nationals residing within the selected informal settlements were seen to share many obstacles relating to availability of and accessibility to health services, though migrants faced additional barriers such as cost discrepancy, real or perceived discrimination, language barriers and identification requirements to receive services.

It is my sincere hope that the findings in this report will stir resolve among the stakeholders, including the government of Kenya, to broaden their activities in implementing the World Health Assembly Resolution 61.17 on the "Health of Migrants". Improving the infrastructure and quality of services, along with the elimination of language barriers and discrepancies in cost, should be at the minimum, a priority to ensure healthy migrants live in health communities.



**Ashraf El Nour**  
**Regional Director, East and Horn of Africa**  
**International Organization for Migration**

## ACRONYMS

<b>APHIA plus</b>	AIDS, Population and Health Integrated Assistance
<b>CBO</b>	Community-Based Organization
<b>CDC</b>	Centers for Disease Control
<b>CISP</b>	Comitato Internazionale per lo Sviluppo dei Popoli
<b>FBO</b>	Faith-Based Organization
<b>FSW</b>	Female Sex Worker
<b>GBV</b>	Gender-Based Violence
<b>GIZ</b>	Deutsche Gesellschaft für Internationale Zusammenarbeit
<b>HIV</b>	Human Immunodeficiency Virus
<b>IOM</b>	International Organization for Migration
<b>MSF</b>	Medecins Sans Frontieres
<b>MSM</b>	Men Who Have Sex With Men
<b>NASCOP</b>	Kenya National AIDS & STI Control Program
<b>NGO</b>	Non-Governmental Organization
<b>NHIF</b>	National Hospital Insurance Fund
<b>TB</b>	Tuberculosis
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>VCT</b>	Voluntary Counselling & Testing
<b>WHO</b>	World Health Organization

## EXECUTIVE SUMMARY

### Background

As a result of the global impact that increasing population mobility continues to impart, the international community has identified the health of migrants as a priority area of concern. In recent years, Kenya's capital city Nairobi has experienced an influx of migrant workers in regular and irregular situations, as well as migrants forced to flee their surrounding countries of origin, or coming from UNHCR-managed refugee camps into the city. Urban migrants regularly face challenges integrating with host communities and consequently may develop health vulnerabilities. The International Organization for Migration (IOM) is the leading inter-governmental agency working to promote migrant health. IOM's Migration Health Department in Nairobi has recently acknowledged a lack of disaggregated information about urban migrants in Nairobi and the health programming available to them in the specific communities where they live. Such information is needed to ensure that health programming can be targeted toward meeting the specific needs of urban migrants, thus contributing to IOM's aim of promoting the health of migrants in healthy communities.

The purpose of this project was to gain a better understanding of the breadth of migrant communities in Nairobi, the health services available to them and the related challenges associated with accessing those services. The results will help to identify programming gaps and inform the development of interventions that will increase and improve accessible and equal service delivery.

More specifically, the project aimed to address the following questions:

- Where are migrant communities located in Nairobi and what migrant categories make up these communities?
- Where are healthcare services that target urban migrants located across Nairobi?
- What are the strengths, weaknesses, opportunities and threats of healthcare services available to urban migrants in Nairobi?
- How do key informants (i.e. government officials, health service providers, migrants, host community members) describe the dynamics between migrant and host communities?

### Study Methods

We identified key informants in collaboration with The National Organisation for Peer Educators (NOPE), and these individuals identified communities within Nairobi where sizeable migrant communities reside. Data from informal discussions were triangulated with data obtained from an extensive review of documents selected for their content relating to urban migrants in Nairobi. Four communities were subsequently selected

for further study based on verbal and written reports of their migrant populations: Mathare, Kayole, Majengo and South B. In each selected community, interviews with government representatives and service providers were conducted, and focus group discussions were held with both migrants and Kenyans residing in each respective community. Overall, eight government representatives took part in informal discussions. Three government representatives and eight health service providers took part in semi-structured interviews.

Eight separate focus group discussions were held with migrant and Kenyan community members from: Mathare (n = 6 migrants; n = 5 Kenyans), Majengo (n = 4 migrants; n = 6 Kenyans); Kayole (n = 6 migrants; n = 5 Kenyans) and South B (n = 5 migrants; n = 4 Kenyans). Verbatim transcripts from interviews were content-analyzed using an open coding technique.

## **Key Findings**

### ***Where are migrant communities located in Nairobi and what migrant categories make up these communities?***

Results confirm that Eastleigh is host to the most identifiable migrant community in Nairobi, yet many other urban migrant communities are dispersed throughout the city, particularly within its informal settlements. Virtually all participants identified specific locations they believed or knew to be populated by migrants. It appears that urban refugees, asylum-seekers and other migrants are likely to congregate in certain locations based on shared nationality, rather than shared immigration status and therefore no pattern was identified with respect to the migrant categories that comprise particular communities.

### ***Where are healthcare services that target urban migrants located across Nairobi?***

Aside from IOM's Eastleigh Community Wellness Centre, no health programming that inclusively targets urban migrants was identified. Programmes targeting certain groups of urban migrants, namely urban refugees, were identified but their services were limited in quantity and scope. Certain programmes were identified that did not target Nairobi's urban migrant population specifically but were nonetheless available for use by urban migrants, irrespective of their immigration status. These latter programs consisted primarily of private and NGO operated facilities.

### ***What are the strengths, weaknesses, opportunities and threats of healthcare services available to urban migrants in Nairobi?***

Strengths of programming included a demonstrated willingness shown by government representatives and healthcare providers to act upon the growing concerns related to migrants and their health. The existence of government initiatives to providing certain services (HIV, TB and pediatric programmes) in public facilities was also an identified strength.

With regard to access to healthcare facilities, four primary dimensions of access exist: availability, geographic accessibility, financial accessibility and acceptability. Several barriers to healthcare access were identified and are considered here as the weaknesses of healthcare programming. Kenyans and migrants shared barriers related to the availability (waiting times), geographic accessibility (lack of transportation, roads, and distance to maternity and emergency services), and to some degree the financial accessibility of services. Barriers experienced exclusively by migrants related mostly to financial accessibility (cost discrepancies between migrants and Kenyans) and to the acceptability of services (real or perceived discrimination, documentation requirements and language barriers), suggesting that urban migrants face unique and perhaps additional challenges in gaining access to an already limited healthcare system.

Opportunities to improve migrant healthcare services exist and are reflected in the relatively recent creation of the ‘Urban Refugee Protection Network,’ which includes representatives from the government, UNHCR, IOM and other NGO organizations. This working group provides a forum to identify, discuss and act upon migrant health concerns, with a particularly important opportunity to involve and hold the government accountable for taking action against disparities in access to healthcare among migrants.

The primary threat identified by the project was an overall lack of funding for public health programming. A lack of knowledge of available programming, poor health-seeking behaviours among migrants, as well as underlying xenophobia were also identified as factors that may threaten existing healthcare programming.

*How do key informants (i.e. government officials, health service providers, migrants, host community members) describe the dynamics between migrant and host communities?*

Reported interactions between migrants and Kenyans by all participants were largely neutral. Several participants contrasted their own communities with Eastleigh, stating that there were comparatively few tensions present outside of that neighborhood. Participants described several detailed benefits and also drawbacks to migration, however, no participants drew direct links between migration and health of the population at large. Some participants, however, believed that disease outbreaks were more likely to occur *within* the migrant communities.

## Recommendations

Stakeholders in migrant health must act on the four pillars put forth by World Health Assembly’s resolution on migrant health, which are: policy and legal frameworks, networks and partnerships, migrant-sensitive services and continued monitoring of migrant health through research.

Policy frameworks are required for strategic funding allocation to the public healthcare system in order to improve the infrastructure and overall quality of services offered to all individuals living in Nairobi. The financial accessibility of public healthcare services should be improved, especially for the most vulnerable members of the community.

Policy and legal frameworks that address and take action toward the elimination of xenophobia are also required, as research has shown that a tactical political response is one of the key ways to address xenophobia in countries with large migrant populations.

Partnerships and networks are required to help support government initiatives and to ensure that related organizations targeting 'vulnerable populations' are not inadvertently failing to include certain individuals - for example irregular migrants. Allied organizations should be aware of one another's activities, in order to both promote collaboration and minimize the duplication of their efforts. Strong referral systems should be coordinated with the government to ensure access to essential healthcare services are provided for every person, regardless of immigration status.

Migrant-sensitive services can be improved in part by eliminating language barriers and discrepancies in charges that restrict access for migrants (Fortier, 2000). Additionally, cultural competence training of healthcare providers who work with diverse client populations and public awareness-raising of the health and social issues related to the experiences of migrants may help contribute to the elimination of attitudes exhibited by healthcare professionals that could potentially be interpreted as discriminatory or xenophobic (Fortier, 2000).

Lastly, continued research in migrant health that includes migration indicators, monitors the positive and negative impacts of urban migration (including growing xenophobia), implements and tests the effectiveness of interventions, and evaluates the related outcomes for *both* migrant and host populations are necessary for the development of sustainable strategies for moving the idea "healthy migrants in healthy communities" forward (IOM, 2011c).

## INTRODUCTION

Population mobility has been recognized as a defining component of the twenty-first century (IOM, 2011c). Economic, sociocultural, environmental and socio-political factors are among the driving forces behind migration (IOM, 2011c). Kenya, due in part to its relative political and economic stability, has hosted a sizeable migrant population comprised of diverse categories of migrants for decades.

Many migrants in Kenya are those who have fled humanitarian crises in neighbouring countries, and have now become members of one of the world's largest refugee populations. Kenya hosts hundreds of thousands of refugees in its UNHCR-managed camps in Northern Kenya. However, the term "refugee" is often used inappropriately to describe Kenya's entire migrant population, which also includes asylum-seekers, and migrant workers in a regular or irregular situation, among others. See below for clarification of the relevant terms as they pertain to this document.

**Migrant:** No universally accepted definition exists at the international level. The United Nations defines migrant as an individual who has resided in a foreign country for more than one year irrespective of the causes, voluntary or involuntary, and the means, regular or irregular, used to migrate. Under such a definition, those travelling for shorter periods as tourists and businesspersons would not be considered migrants. However, common usage includes certain kinds of short-term migrants, such as seasonal farm-workers who travel for short periods to work planting or harvesting farm products (IOM, 2011e).

**Refugee:** A person who meets the eligibility criteria under the applicable refugee definition, as provided for in international or regional refugee instruments, under UNHCR's mandate, and/or in national legislation (UNHCR, 2006).

In Kenya, according to the Refugee Act of 2006, a refugee is a person:

- (a) who owing to a well-founded fear of being persecuted for reasons of race, religion, sex, nationality, membership of a particular social group or political opinion is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country (UNHCR, 1951); or
- (b) not having a nationality and being outside the country of his former habitual residence, is unable or, owing to a well-founded fear of being persecuted for any of the aforesaid reasons is unwilling, to return to it.

**Asylum-seeker:** An asylum-seeker is an individual who is seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee is initially an asylum-seeker (UNHCR, 2006).

**Migrant Worker:** A person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national (article 2(1), International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW), 1990).

Article 2 of the ICRMW also provides for different categories of migrant workers. The term frontier worker refers to a migrant worker who retains his or her habitual residence in a neighbouring State to which he or she normally returns every day or at least once a week. An itinerant worker refers to a migrant worker who has to travel to another State or States for short periods owing to the nature of his/her occupation. Among others, truck drivers, cross border traders, boda-boda, and migrant women sex workers are migrant workers.

**Family members of the migrant worker** are defined to include common law spouses, dependent children and other dependent persons (see article 4 of ICRMW).

Migrant workers and members of their families are considered as: (a) **documented or in a regular situation** if they are authorized to enter, to stay and to engage in a remunerated activity in the State of employment pursuant to the law of that State and to international agreements to which that State is a party (b) **non-documented or in an irregular situation** if they do not comply with the conditions provided for in subparagraph (a) of the present article (article 5 of ICRMW).

More generally, **a migrant in an irregular situation** 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.

## Urban Migrants in Kenya

Nairobi, the capital city of Kenya is widely considered to be the economic hub of East Africa and has for decades been attracting migrants to the city. Among them are job seekers, migrant workers including those in an irregular situation who are seeking informal employment, as well as refugees and asylum-seekers who are leaving the overcrowded refugee camps in the north for Nairobi.

Overall an estimated 46,000 refugees and 11,000 asylum-seekers reside in Nairobi (UNHCR, 2011). Formal population data on the urban migrant population that is inclusive of migrant workers, including those in an irregular situation is not available, owing largely to the challenge of collecting this information through official means. It is estimated to be between 80,000 and 100,000 (Campbell et al., 2011).

Nonetheless, the presence of urban migrants residing in the Eastleigh area of Nairobi is well documented (Campbell, 2006; IOM, 2011a; Pavanello et al., 2010; WHO, 2010). Eastleigh is a large suburb with a flourishing economy and known to house predominantly Somali and Ethiopian migrants – some of whom have irregular migrant status (Campbell, 2006; IOM, 2011a). Other irregular migrants are known to reside elsewhere in Nairobi, and have been cited as being dispersed throughout informal settlements across the city (Dix, 2006; Pavanello et al., 2010).

## Migration and Health

There is increasing consensus within the international community that migration itself is a determinant of health because it fuels inequities that cross-cut biologic, lifestyle, community, employment, socioeconomic, cultural and environmental factors (IOM, 2011b). By virtue of enduring circumstances that often 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 often encounter unique health vulnerabilities (Carballo & Nerukar, 2001; IOM, 2011c). The consequences of such vulnerabilities are not experienced by migrants alone, but also by the communities with which they interact.

The International Organization for Migration (IOM)'s "spaces of vulnerability" approach is based off the same understanding - that "health vulnerability stems not only from 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" (SAMP, 2002). Spaces of vulnerability are locations where the health of individuals is at risk and 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). Therefore, addressing the health needs of the migrant population in Nairobi is in the best interest of the population at large (IOM, 2011c).

Eastleigh is regarded as a space of vulnerability because of the significant migrant population that lives there and the innumerable ways that the migrant population interacts with the host population. Evidence of health disparities among urban migrants residing in Eastleigh has been shown with respect to tuberculosis, reproductive and maternal child health, malaria, measles and psychosocial health (IOM, 2011a). Eastleigh was excluded from the current project due to the presence of existing IOM programming in the area, as well as the breadth of research that has previously been conducted there.

Additionally, Nairobi's informal settlements are densely populated areas that are likely to attract migrants due to: social ties; availability of housing; low cost of living; and for irregular migrants, the ability to remain uninterrupted by authorities (IOM, 2011c; Pavanello et al., 2010). Therefore for this project, migrant health was addressed with particular focus on those migrants residing in the city's informal settlements.

## Health Policy

The 2010 Constitution of Kenya declares that “a fundamental duty of the State is to fulfil the rights of every person in Kenya, including the right to the highest attainable standard of health” (Republic of Kenya, 2010). In addition, having ratified the 1951 United Nations Convention and 1967 Protocol relating to the Status of Refugees, as well as the 1969 Organization of African Union Convention Governing the Specific Aspects of Refugee Problems in Africa, Kenya has a duty to protect the rights of refugees and asylum-seekers.

Further, in 2008 the World Health Assembly passed resolution 61.17 on the health of migrants, calling upon its member states, including Kenya, to “recognize the health of migrant populations as a human right by monitoring migrant health and strengthening migrant sensitive health systems” (WHO, 2010). In March 2011, in order to begin materializing the WHA 61.17 resolution, the Kenya Ministry of Public Health and Sanitation, in collaboration with the International Organization for Migration and the World Health Organization (WHO), hosted the *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, the consultation drew various stakeholders together in order to formulate a common action plan for providing accessible, affordable and non-discriminatory healthcare to all people in Kenya (IOM, 2011c; Republic of Kenya, 2005).

Participants of the 2011 *National Consultation on Migration Health* identified a lack of disaggregated strategic information on urban migrants and their health, resulting in a lack of programming and likely contributing to inequitable access to healthcare across the country. The government specifically asked for IOM’s assistance in addressing the concerns related to the health of a rapidly expanding urban migrant population in Nairobi. Therefore, IOM in collaboration with McGill University in Montreal, Canada, designed and conducted a research project that involved mapping various urban migrant populations in Nairobi, as well as performing an operational assessment of the health programs that target them. The aim was to identify gaps in programming and identify the particular health vulnerabilities of urban migrants in Nairobi.

## Access to healthcare in Nairobi

Of particular concern to the migration health division at IOM is the marginalization of migrants from mainstream health programmes, which is believed to be imparted by certain barriers including but not limited to: immigration status, communication barriers, poverty, cultural beliefs and gender norms (IOM, 2011a). Data gaps in epidemiology, health risk, and the health-seeking behaviours of migrants intensify the issue and create challenges for creating and implementing strategic interventions that are targeted at improving the accessibility of healthcare to this population (IOM, 2011a).

At the time of this study, the public health system in Kenya was administered by the Ministry of Health, comprising the Ministry of Public Health and Sanitation and the Ministry of Medical Services. The government works in partnership with many organizations, notably USAID/Kenya and Pathfinder International, which implemented the AIDS, Population and Health Integrated Assistance (APHIPlus) project in Kenya's urban centres in 2011 (USAID, 2011).

Public service delivery comprises a multi-level system, with city council clinics as the most common point-of-entry. All people residing in Nairobi should be able to access services provided at city council clinics (e.g. laboratory, TB, HIV comprehensive care, VCT, antenatal care, immunizations and family planning services), for a KSh 20 registration fee. If further treatment is required, users will be referred to 4<sup>th</sup> and 5<sup>th</sup> level facilities such as Pumwani Maternity Hospital or the national referral hospital – Kenyatta National Hospital - where they will be charged for services. Fees are reimbursed to members of the National Hospital Insurance Fund (NHIF) if the facility is accredited by the NHIF board (Deloitte Consulting, 2011). Non-nationals are eligible to apply for membership to the NHIF, but must provide a passport and a student visa or work permit in order to do so.

Private facilities are abundant in Nairobi and range from small clinics to hospitals fully-equipped with operating theatres and specialized care units. A major drawback of private facilities is that their costs are high in comparison to public services and therefore restrict access for those who cannot afford them. They may also be unregulated and unlicensed. Nonetheless, private services are often the only option for migrants requiring services who are unwilling to attend public facilities for fear of identification, expulsion and detention.

Additionally, there are many NGOs, CBOs and FBOs that offer healthcare services and health-related assistance. These services are sometimes provided free of charge, but may require a small fee to support their operational costs (Mapendo International, 2010). In some cases, these services require identification, though not necessarily Kenyan, for administrative purposes.

Health programming that specifically targets urban migrants is provided by UNHCR and partners as well as additional NGOs and refugee protection agencies that operate in Nairobi, however, these services generally require registration with the UNHCR or Department of Refugee Affairs. The IOM Eastleigh Community Wellness Centre offers health services to both migrants, including asylum seekers, refugees, migrant workers, and host community members (IOM, 2010). Programmes include reproductive and child health services, HIV and tuberculosis programming and other communicable disease prevention programmes (IOM, 2010).

## Research Objectives

The purpose of this study was to gain a better understanding of the breadth of migrant communities in Nairobi, the health services available to them and the related challenges associated with accessing those services. Results will help to identify programming gaps and inform the development of interventions that will increase and improve accessible and equal service delivery.

## Research Questions

1. Where are migrant communities located in Nairobi and what migrant categories make up these communities?
2. Where are healthcare services that target urban migrants located across Nairobi?
3. What are the strengths, weaknesses, opportunities and threats of healthcare services available to urban migrants in Nairobi?
4. How do key informants (i.e. government officials, health service providers, migrants, host community members) describe the dynamics between migrant and host communities?

## METHODS

A qualitative descriptive design was used for the project. Sandelowski (2000) recommends this research design when aiming to improve the understanding of a topic for which little is already known and when straight descriptions of data and observations are desired. With a limited scope of existing information about the migrant population in Nairobi, qualitative descriptive methodology provided a systematic yet flexible way to understand the inside perspectives of participants most knowledgeable about our research topic.

This project is the result of a continuing partnership between the Ingram School of Nursing at McGill University in Montreal, Canada and the IOM Migration Health Division in Nairobi, Kenya. IOM provided logistical support for the local transportation of one of the authors and the participants of focus groups, as well as the remuneration for a research assistant for support with data transcription and translation. Ethical approval was obtained from the Faculty of Medicine's institutional review board at McGill University and a community approval agreement was made with members from each of the study locations. Prior to each interview, consent was obtained from all participants, with a translator present to ensure participation was fully informed and voluntary. Participants did not receive compensation for their participation.

### Data Collection

Data collection took place across the city of Nairobi, with the exception of Eastleigh area, between September and December 2012. Eastleigh was excluded from the study because a significant amount of research had previously been conducted there, and because its migrant presence is relatively well-described in various existing reports (IOM, 2011a; Pavanello et al., 2010).

Participants were purposively selected in collaboration with the National Organisation for Peer Educators (NOPE), due to this organization's involvement and positive reputation with government programme representatives, service providers and community members, including migrants. Participants were recruited using a snowball sampling method, which is useful when participants include hard-to-reach populations such as irregular migrants, or small specific populations such as service providers knowledgeable on a certain topic (Polit & Beck, 2008).

With the assistance of NOPE, the researchers were able to contact representatives from the eight administrative divisions of Nairobi. One government representative (Embakasi division) who was recruited to the project was ultimately unable to participate. The remaining eight representatives participated in informal discussions about the locations of migrant communities within the city. Data from informal discussions were triangulated with data obtained from review of relevant documents selected for their content relating

to migrant or specifically refugee health in Nairobi. Four specific locations were initially cited most often as being highly populated by migrants (excluding Eastleigh) and were consequently selected for further study: Mathare, Kayole, Majengo and South B.

In each of the four selected locations, one government programme representative, two service providers, 4-6 migrants and 4-6 Kenyans agreed and provided written consent to take part in the project. NOPE provided contact information for service providers in each location. The service providers were contacted by phone or email and asked to participate or to refer us to service providers with an interest in migrant health. Migrants and host community members were recruited with the assistance of a willing community member from each study location, identified through NOPE or a partnering organization. In two instances the community leader was a service provider and in two instances was an individual with past experience as a migrant community representative. Inclusion and exclusion criteria for each participant group are outlined in Table 1.

TABLE 1: INCLUSION CRITERIA BY PARTICIPANT GROUP

Participant Group	Inclusion Criteria	Exclusion Criteria
Government-programme representative	<ul style="list-style-type: none"> <li>• Holds a position with the Government of Kenya (Ministry of Public Health and Sanitation or the Ministry of Health Services)</li> <li>• Adult</li> </ul>	<ul style="list-style-type: none"> <li>• Declined consent</li> <li>• Major hearing or cognitive impairment that prevents giving fully informed consent</li> </ul>
Health service providers	<ul style="list-style-type: none"> <li>• Can speak and understand English or Kiswahili</li> <li>• Has held a position within a public, private, faith-based or NGO health service facility in Nairobi for at least 1 month</li> <li>• Adult</li> </ul>	
Member of migrant community	<ul style="list-style-type: none"> <li>• Self-identifies as a migrant</li> <li>• Adult</li> </ul>	
Member of host community	<ul style="list-style-type: none"> <li>• Can speak English or Kiswahili</li> <li>• Born in Kenya</li> <li>• Adult</li> </ul>	

## Semi-structured interviews

One-on-one semi-structured interviews were conducted in English with all government programme representatives (n = 3) and service providers (n = 8) who participated. In all cases, government programme representatives were the same individuals who took part in initial informal discussions in their respective locations. Interviews were held at a time and place of the participant's convenience and lasted 25-60 minutes. The semi-structured interview guide was designed to elicit an overall assessment of the healthcare services being provided as well as the presence of other healthcare services available in the participant's respective project location.

## Focus group discussions

Two focus group discussions were held with migrant and Kenyan community members from Mathare (n = 6 migrants; n = 5 Kenyans), Majengo (n = 4 migrants; n = 6 Kenyans); Kayole (n = 6 migrants; n = 5 Kenyans) and South B (n = 5 migrants; n = 4 Kenyans). When necessary, a translator was present to permit participants to respond in Kiswahili if desired. Participants were recruited with the assistance of a volunteer community leader who was instructed on the principles of consent and who agreed to help locate migrants and Kenyans residing in that location who were willing to participate. Migrants were not asked for identification in order to avoid mistrust or suspicion regarding the project. Migrant status was only disclosed within the focus group discussions and only by those willing to do so. Migrant categories that were represented included refugees, asylum-seekers and other migrants, some of whom were in an irregular situation. The countries of origin of migrants were: Democratic Republic of Congo, Ivory Coast, Tanzania, Uganda and Rwanda, but participants were not recruited based on nationality. Focus groups discussions lasted 40-70 minutes and when possible were held at a venue within the community. However, due to security and logistical constraints, the majority of focus groups were held at the IOM regional office.

## Data Management & Analysis

Verbatim interview and focus group transcripts were translated to English from Kiswahili (where necessary) and transcribed. All of the transcripts were read through in full, with emerging themes and commonalities noted. A template coding process followed, whereby transcripts were re-examined line by line and codes were assigned to selected portions of the text based on their correspondence with the particular research question that was being addressed (King, 2004). Interpretive analysis followed, where conceptual links were established and compared between participant groups and their respective locations.

To address research question one concerning the locations and densities of migrant communities, the researcher kept a running log of quotations that pertained to the same and judged each comment as reflecting either a large or moderately sized migrant population. For example, words like “many”, “a lot” and “high” were considered comments that reflected large populations and words like “a few” and “some” were considered to reflect moderately sized populations. These data were represented using Google Maps™ software in Figure 1. Google Maps™ software was chosen because it is widely available, it can effectively display the desired data, is user-friendly, does not require working with complicated data sets, allows for mapping using streets and roads as opposed to GPS coordinates and because Google software has been used for similar research by international agencies in the past (Jacobsen & Nichols, 2011).

To address research question two concerning the locations of healthcare facilities available to migrants, a compilation of facilities was produced during analyses of semi-structured interviews and focus group discussions. Healthcare facilities were included only if migrants reported using them or if service providers stated that their facility was available to migrants. Facilities were then located and tagged using Google Maps™ software and are represented in Figures 2 – Figure 5. Names of facilities shown in the figures as well as those that were mentioned by participants but were unable to be located are included in Appendix 1.

## RESULTS

**Question One:** Where are migrant communities located in Nairobi and what migrant CATEGORIES make up these communities?

Initial informal discussions with government officials revealed a number of locations where large populations of migrants were believed to be living - primarily within Nairobi’s informal settlements. The four most commonly referenced areas that were chosen for further investigation were: Mathare, Kayole, Majengo and South B.

Following initial informal discussions with government representatives and throughout the project, migrant communities continued to be identified by participants. These accounts were included in the analyses and compilation of Figure 1; however, due to time and logistical constraints no further participants were recruited from these areas. A brief description of the four specific locations chosen for investigation and others that were subsequently identified follows.

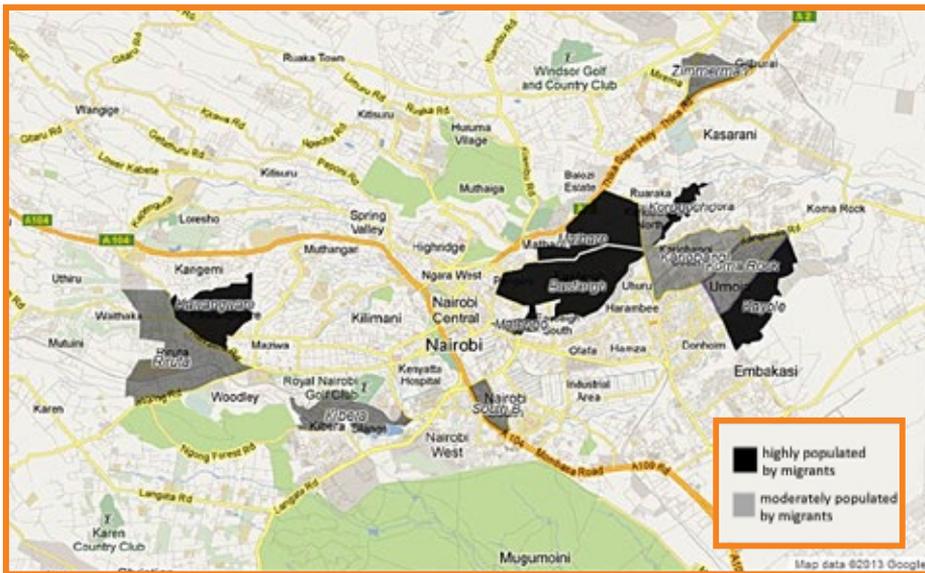


FIGURE 1: LOCATIONS AND ESTIMATED RELATIVE DENSITY OF MIGRANT COMMUNITIES IN NAIROBI

### MATHARE

Mathare is located to the northeast of Nairobi’s city centre in Starehe district. It is divided into Mathare North, Mathare South and Mathare Valley, the latter of which is comprised of the second largest informal settlement in Nairobi. Bordering Mathare to the south is Juja Road, which separates Mathare from Eastleigh. The primary reason urban migrants reported choosing to live in Mathare was the low cost of housing and

food. The majority of key informants reported Mathare as being highly populated by urban migrants. Participants from Mathare described the migrant population as being primarily Ugandan, Congolese and Sudanese. Participants also knew migrants living in Mathare from Ethiopia, Eritrea, Nigeria, Tanzania and Somalia.

## **KAYOLE**

Kayole is located within Embakasi district about 12 kilometres east of the city centre. It is divided into Kayole Central and Kayole South, and is comprised of informal settlements, including Soweto. Participants referenced the affordability of housing and food as their reason for residing in Kayole and described the migrant population as a diverse group of Congolese, Rwandese and Ugandan individuals.

## **MAJENGO**

Majengo is in Pumwani district, about 1 kilometre south of Pumwani Maternity Hospital and less than a kilometre west of Eastleigh section III. Majengo is a smaller informal settlement compared with Mathare and Kayole, and is well known for its availability of sex work. Participants from Majengo described the migrant population there as primarily Tanzanian and primarily consisting of female sex workers. Participants from Majengo also knew of Rwandese and Somali migrants living in the area. The primary reason participants reported for living in Majengo was the low cost of living, and for sex workers, the availability of clients.

## **SOUTH B**

South B is in Makadara district and comprised of a few small informal settlements as well as formal residential areas. It neighbours Nairobi's industrial area, and residents reported good security and availability of employment in factories and warehouses, as well as ties to the existing migrant community and proximity to the city centre as reasons for residing in South B. South B was initially identified by government programme representatives as being populated by a substantial migrant population; however migrants who lived there tended to describe a moderately sized population, as reflected in Figure 1. The migrant population was described as being Burundian, Congolese, Ethiopian, Rwandese, and Somali.

## **OTHERS**

Other locations that were stated to have considerable migrant populations were: Kibera, Kariobangi, Korogocho, Koma Rock, Kawangware, Riruta, Zimmerman and Eastleigh. Kibera is Nairobi's largest informal settlement and while the population of Kibera is believed to be predominantly Kenyan, several participants stated that it may also be home to a sizeable migrant population, particularly Congolese, Ugandan and Somali migrants. Kariobangi, Korogocho and Koma Rock are located in Eastlands, between Mathare and Kayole, and were each considered by participants to be informal

settlements populated by migrants. Kawangware and Riruta border each other in the west of Nairobi. These two locations were believed to be populated by migrants with diverse nationalities. Eastleigh, as mentioned, is perhaps recognized as the area with the largest migrant community, primarily of Somali and Ethiopian origin.

Overall, the findings represented in Figure 1 suggest that urban migrant communities are located in many areas throughout the city, particularly within informal settlements. There were no participants that did not verbalize locations they believed or knew to be populated by migrants. However, no particular pattern was discerned concerning the specific migrant categories that these communities were comprised of. Rather, it appeared that urban refugees, asylum-seekers and other migrants were more likely to congregate in certain locations, even within a localized informal settlement, based on shared nationality, but do not necessarily congregate based on shared immigration status. Many participants described instances where they were assisted upon arrival to Nairobi by friends or family members from their country of origin who had already established themselves, and subsequently settled in the same area.

### Question Two: Where are healthcare services that target urban migrants located across Nairobi?

No programmes were identified in the four study locations that exclusively targeted urban migrants as their catchment population. However, programmes targeting certain groups of urban migrants, namely urban refugees, were identified. Asylum-seekers were able to access the majority of these services also. The locations of facilities identified by participants as providing these services are indicated in Figure 2 through Figure 5 below.

Certain programmes were identified that did not target Nairobi's urban migrant population specifically but were nonetheless available for urban migrants. For example, NOPE's Sasa Centres, which target FSWs and MSMs offer their services irrespective of nationality and immigration status. Blue House, run by MSF France, reportedly provides HIV, TB and emergency GBV services regardless of status, according to participants outside of this organization. Other NGO-, CBO- and FBO-run programmes that were accessed by urban migrant participants are indicated in the figures below. Many of these programmes focus specifically on one or two areas of services provision (e.g. antenatal care, HIV treatment, or VCT). See Appendix 1 for names of facilities mentioned by participants for which a location could not be identified.

Note that the following figures are a representation of the facilities that were explicitly named by migrant participants and therefore portray the best possible estimation based on the study data of where migrants are accessing healthcare in the four study locations. They do not, however, claim to be exhaustive, nor do they represent the availability of programming for migrants residing outside of the four study areas (Mathare, Kayole, Majengo and South B).

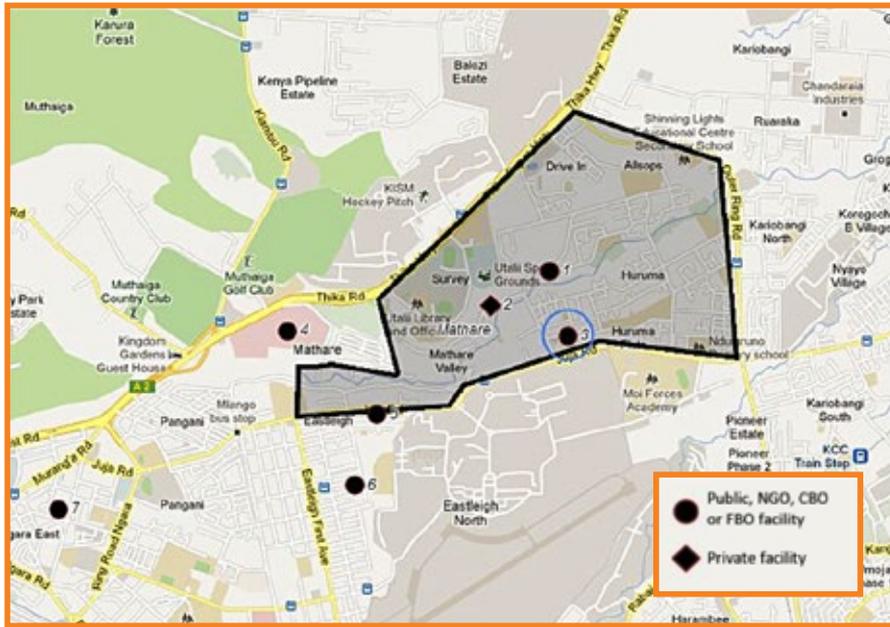


FIGURE 2: LOCATIONS OF HEALTH FACILITIES ACCESSIBLE TO MIGRANTS NEAR MATHARE

1. Mathare North Health Clinic; 2. Baraka Medical Centre; 3. Lions Health Clinic; 4. Mathare Psychiatric Hospital; 5. MSF France Blue House HIV/TB Clinic; 6. Eastleigh Maternity Clinic; 7. Ngara City Council Clinic

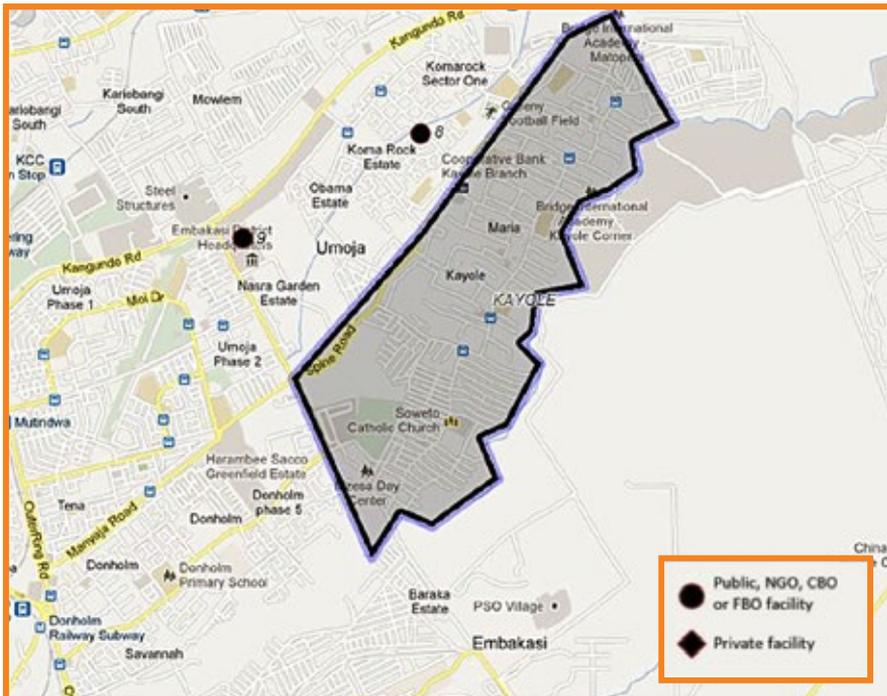


FIGURE 3: LOCATIONS OF HEALTH FACILITIES ACCESSIBLE TO MIGRANTS NEAR KAYOLE

8. Gertrude’s Children’s Hospital; 9. Mama Lucy Kibaki Hospital; 10. St. Mary’s Hospital



FIGURE 4: LOCATIONS OF HEALTH FACILITIES ACCESSIBLE TO MIGRANTS NEAR MAJENGO  
 11. Pumwani Maternity Hospital; 12. Majengo City Council Clinic; 13. SWOP Majengo Clinic

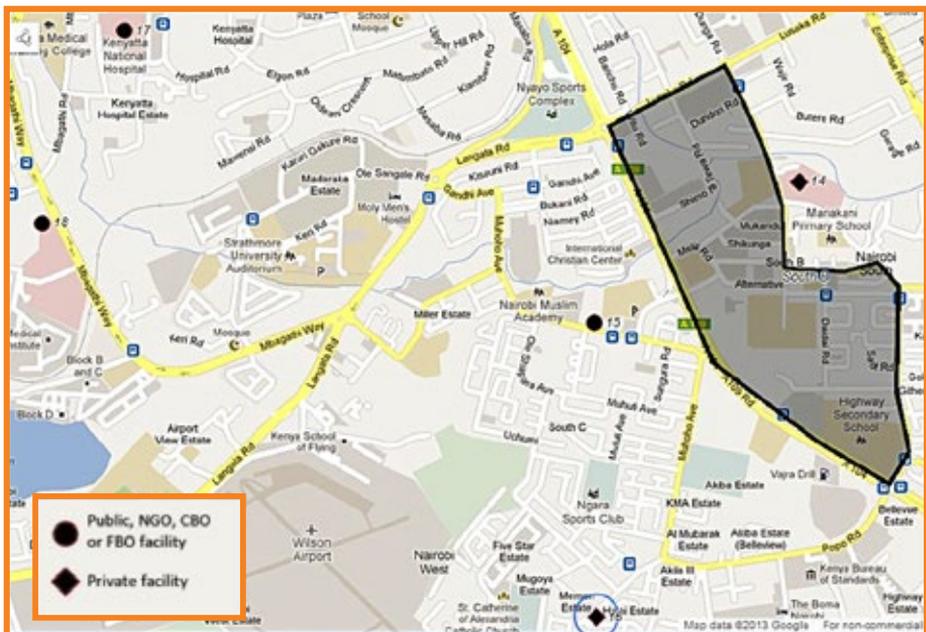


FIGURE 5: LOCATIONS OF HEALTH FACILITIES ACCESSIBLE TO MIGRANTS NEAR SOUTH B  
 14. The Mater Hospital; 15. City Council of Nairobi Clinic; 16. Hallen Medical Clinic; 17. Kenyatta National Hospital; 18. Mbagathi District Hospital

Participants reported that to access healthcare services at private facilities, they were unlikely to encounter issues related to their immigration status, yet there were very few private facilities that migrants reported actually receiving services from. This was repeatedly stated to be due to the high cost of such services.

The situation for the city council clinics appeared to be more complex. According to government programme representatives and certain service providers, services at all city council clinics are available to migrants and non-migrants at a cost of KSh 20 for registration. However, several service providers, host community members and migrant participants reported that migrants are asked to pay up to KSh 300 for services. At some city council clinics and not others, it was reported that documentation or identification is required in order to register for services. Therefore, if one did not have a passport or Kenyan national ID (whether a migrant or a Kenyan), they would not be able to access services at every city council clinic. Barriers to accessing the services are discussed further in the following section.

### Question Three: What are the strengths, weaknesses, opportunities and threats of healthcare services available to urban migrants in Nairobi?

This section reports findings that comprise a general assessment of the healthcare services available for urban migrants in Nairobi. It describes an overall picture of the common strengths, weaknesses, opportunities and threats of migrant health programming that were uncovered in the project locations. Findings relating only to specific project locations are otherwise indicated.

#### STRENGTHS

A notable strength that was continuously demonstrated by government programme representatives and healthcare providers was an open willingness to recognize and take action on the growing concerns related to urban migrant health. For example, one government programme representative stated: “We need to know more about migrants and what they need. I don’t think most people are sensitized on migrant health.” Other service providers explicitly stated their willingness to assist, given the necessary support to do so. For instance:

“You see, everybody’s important, no matter their walks of life, and if we can get better services, everyone should be entitled to get better services no matter where they come from.” *–NGO service provider*

“If we can have an interpreter so that when [migrants] come we are able to understand what they are telling us, we are in a position to offer them services.” *–public service provider*

“I am wondering how I could reach them if there were any new [migrants] that have just come to the area.” *–NGO service provider*

Similarly, the existence of the public city council clinics can also be considered a strength. In each of the project locations, the majority of participants from all participant groups – migrants, Kenyans, services providers and government programme representatives provided names and sites of public services that were available to residents of the area. Government initiatives, in partnership with APHIA plus, to provide free HIV, TB and pediatric (less than 5 years) programming was confirmed by participants. While facilities providing such services were not necessarily located within the borders of the particular study location, in most cases they were within walking distance.

Two exceptions reported by both migrants and Kenyans from Mathare and Kayole were emergency and maternity services. Participants from Mathare highlighted the challenges for women, particularly at night, of “climbing out of the slum” once they began to experience labour contractions. Similarly, residents of Mathare and Kayole described the absence of transportation or ambulance services due to lack of roads, or poor conditions of the roads.

## WEAKNESSES

Despite the existence of public city council clinics, results suggested that these services may be overly burdened by their demand. Long wait times at public and some NGO services were reported by both migrants and Kenyans. Both groups described scenarios where individuals had to wake up before dawn to get to public clinics, where individuals were being consistently turned away from health facilities at the end of the day, and of witnessing people “dying while in the queue”. Government officials, service providers, migrants and Kenyans also reported limited availability of drugs within public facilities, and in some cases, described this as a factor leading them to purchase drugs without a prescription at dispensaries to “save time”.

Many participants also reported inconsistencies between the *availability* of services and their *acceptability*. Four main themes emerged and were noted to be present as barriers of particular importance for urban migrants across all of the study locations: a) cost discrepancies between migrants and Kenyans; b) real or perceived discrimination; c) documentation requirements and; d) language barriers.

### ***Cost discrepancies between migrants and Kenyans***

Participants described a requirement for migrants to pay a higher rate for services at the public city council clinics. This cost differential was described not only by migrants, but also by Kenyans and by service providers who were not employed at public clinics. For example, an NGO service provider stated, “I know that some clinics they make refugees pay more” and another said, “yes [migrants] would be able to access the public services, just at a premium.” One migrant participant reported: “It’s not 20 shillings. We are asked to pay maybe 150, 200, 300, but not 20, that is for Kenyans.”

There was an apparent discord between the above statements and what government representatives and service providers from public clinics reported. One public service provider stated that: “If you can pay the 20 shilling fee then we have no restrictions for migrants so they can access healthcare.” Similarly, a government programme representative said that: “[It costs] 20 shillings for every person over 5 years coming for curative services. But, TB it’s free, VCT is free, and [comprehensive care] is free.”

When migrants were asked if they were offered a rationale for having to pay more than the KSh 20 registration fee at public clinics, many stated that they had never thought to because “they were not in a position to do so”. No service providers or government representatives referred to any policy that required migrants to pay the additional fee. The cause of the discrepancy was therefore unclear, but it should be noted that none of the participants who took part in this project were responsible for the collection or handling of fees at their respective clinics. No administrative or clerical staffs were interviewed.

The same discrepancy was not evident for services offered by the private sector. Participants described the superiority of private services with respect to wait times, quality of services, and for migrants, equal treatment. However, they described private services as being more expensive overall. Many participants, especially migrants, reported not being able to afford services provided at private clinics, however, some participants from South B and Kayole used them occasionally. Kenyans also described private services as expensive, but many tended to favour their use over the public services.

### ***Real or perceived discrimination***

As mentioned, lack of available drugs at public facilities was widely illustrated. However, a notable difference between migrants and Kenyans was that Kenyans tended to report the drug shortage as a widespread challenge related to system shortages, whereas migrants tended to view it as the provider purposely withholding drugs for treatment. Service providers reported that, “clients are given whatever is there” and “usually they don’t have enough”, and Kenyans said that medications were “very hard to get.” On the other hand, migrants appeared to interpret lack of drug provision as directly related to their immigration status, without acknowledging a widespread shortage. Examples were:

“When we visit the city council they don’t give us drugs ‘cause we migrants, so we just buy at the chemist.” –*migrant*

“I was told that it is a hospital for the citizens not for foreigners so if you have a job here and you are taking their drugs then you have to pay more because you are taking the drugs for the citizens.” –*migrant*

One participant described a scenario of perceived discrimination that resulted in failure to receive treatment:

“The doctor saw my document and asked if I was a Kenyan and I said ‘no’. Then he took a paper and wrote [on it] and sent me to a private clinic and I did not go there since I did not want to spend more money.” –*migrant*

Another participant described a second-hand account of discrimination that led to their reluctance to seek future services from that particular facility:

“I heard from a friend who took her kid to the hospital [that] she was charged - and normally children below 5 years they don’t pay - this one was charged and she had to look for help from well-wishers in order to pay for the bill. I avoid Kenyatta hospital<sup>1</sup> just because of that.” –*migrant*

### **Documentation requirements**

The majority of participants did not have to show documentation to access services at city council clinics. Users were only required to provide their personal information verbally in order to obtain a clinic card. For secondary and tertiary government facilities, identification of some sort was required but did not necessarily have to be Kenyan. When identity documents were used, however, migrants were then charged larger fees, but this may be as a result of membership with the NHIF.

Several organizations that operate in Nairobi were described as providing various forms of support - including healthcare – to only the refugee and asylum-seeker subgroups of urban migrants, but not to irregular migrants with no documentation or proof of identity. Irregular migrants were reported to be unable to access the services of certain NGOs and CBOs as a result of a requirement to provide official identification upon registration. Participants generally seemed to perceive this barrier as driven by administrative processes. For example, one NGO service provider described that: “we request documentation and the standard identification in Kenya is an identity card or a passport or something.” Another reported that:

“To access services, like health services but also other trainings like whatever services we provide we require that the beneficiary is either a refugee or they’re asylum seekers. Let’s say generally to be legally present in Kenya.” –*NGO service provider*

1 Kenyatta National Hospital is the national referral hospital. Payment is required for treatment to be given, except for needy cases in which a social worker, after assessment, can request payment to be waived.

Another issue relating to documentation was fear of arrest or harassment by the police while traveling to or returning from a hospital or clinic, especially for irregular migrants without formal documentation. Migrants described neighbours who “hide in the slums and don’t want to come out.” One participant who is an irregular migrant described avoiding travelling to access services for the same reason: “You might get [a] policeman on the street and they will ask you to produce ID and if you don’t have [it] you will be arrested and that is on your way to [the] hospital or back from the hospital.” In other cases, possession of a Mandate Refugee Certificate or proof of asylum-seeker status from UNHCR was reported to prevent difficulties with the police: “with the mandate [the police] give you some kind of respect. But without the mandate they disturb you.”

### ***Language barriers***

In Mathare and Majengo, which border Eastleigh, government representatives and service providers considered language as a major barrier for providing services to migrants. For example:

“If we can have an interpreter so that when [migrants] come we are able to understand what they are telling us, we are in a position to offer them services.” *–public service provider*

“If they have a language barrier then that would limit the access. Like the Somali community, that is a problem, yeah.” *–government programme representative*

“We have no restrictions for migrants so they can access healthcare. The only limitation would be language barrier.” *–government programme representative*

Government programme representatives and service providers from Kayole and South B also agreed that language acts as a barrier that restricts access for migrants. Only NGO-provided services had interpreters available. Migrants themselves discussed language barrier as a factor that limits access to services for members of their communities; however, since all participants of the study could speak Kiswahili and/or English and therefore did not report experiencing language barriers themselves.

## **OPPORTUNITIES**

In response to a previously identified lack of coordination between organizations concerned with refugee health, the “Urban Refugee Protection Network (URPN)” was assembled. This working group represents a key forum for partners with a shared interest to discuss, strategize and collaborate in their efforts. Represented in the network are UNHCR, IOM, CDC, GIZ, Refugee Point, CISP, World Friends and the Matibabu Foundation, an IOM partner providing services in Eastleigh. This forum provides an important opportunity, among others, to discuss among partners both the importance

and the challenges of programming that is inclusive of all migrants, and to generate a better understanding and consensus of where one partner's role ends and the other begins. One of the goals of this group is to develop and test a referral system among its members with the aim of ensuring that gaps get addressed and begin to close.

Another opportunity that exists for migrant health programming overall is the use of strategically selected community mobilizers or "super mobilizers." It was noted through both verbal reports and through the researcher's experiences with recruitment of migrant participants for the study that the migrant community is a close-knit one and that information is readily passed by word-of-mouth. This strategy appears to be effective according to one of the service providers whose programme targets female sex workers – a population whose characteristics were described as being similarly close-knit.

## THREATS

The primary threat for the healthcare system as a whole, for migrant health programming, and to individual programmes and facilities is resource and fund allocation. Several government programme representatives and NGO service providers, whether or not they provided services to migrants, described funding and a lack of resources, specifically drugs, as their biggest concern toward their respective health programme.

A potential lack of knowledge and/or poor health-seeking behaviours among migrants was also reported to threaten the utilization of available health programming. In reference to outreach vaccination campaigns, one government representative stated that "some [migrants] lack info and some just ignore [it]". Similarly, few migrants who participated in the study were familiar with the IOM Eastleigh Community Wellness Centre. One participant had heard of it, but did not know where it is located. No one had accessed services there. While this study purposefully did not recruit migrants living in the same area as the clinic, it is notable that the clinic's service delivery has not yet reached its neighbouring areas.

Other participants described "not leaving their posts to access healthcare because of lost earnings." One service provider described that migrants in the area "don't want to take the time to go to clinics if they don't get drugs and just get [a] prescription, so they will just go to a [pharmacy] to save time."

## Question Four: How do key informants describe the dynamics between migrant and host communities?

Overall the interactions between migrants and Kenyans in the four project locations were largely reported to be neutral. Participants said things like: "It's hard even to tell one migrant from one Kenyan" and with respect to living in a diverse community one

participant stated, “It’s just a normal thing.” Others described that: “There are no issues. Everyone gets along” and that migrants “are generally well accepted ‘cause some of them have been here so long and they are well integrated.” Participants, both migrants and Kenyans, often contrasted the communities they lived in with Eastleigh, saying that in comparison there were comparatively few tensions among migrant and host populations. No comments were made that were directly negative toward migrants, however participants described tensions in Eastleigh as a challenge and believed that security threats in and around Eastleigh impacted the public’s perception of the migrant population there.<sup>2</sup>

When asked of the benefits and the related drawbacks that migrants brought to their communities, participants listed several of both, outlined in Table 2 below. Interestingly, few participants spoke of any relationship between migration and health of the Kenyan population. They did, however, believe that disease outbreaks were more likely to occur *within* the migrant communities and to affect them more frequently. They also spoke of a potential strain on resources that could indirectly impact health.

Among migrants, there was a notable perception that Kenyans got priority treatment over migrants. One participant explained: “They treat Kenyans first unless you happen to be sick and someone feels mercy for you.” Migrants from South B explained that Kenyans believe they have a lot of money”, or “a lot of support from the United Nations” and therefore do not need to provide them with additional services.

TABLE 2: BENEFITS AND DRAWBACKS OF MIGRATION REPORTED BY PARTICIPANTS

Benefits	Drawbacks
Culture	Strain on infrastructure
Diversity	Belief that migrants do not contribute as taxpayers <sup>1</sup>
New languages and skills	Increased cost of housing
More businesses	Overcrowding
Competition and motivation	Disease outbreaks

### Study limitations

The primary limitation of the project is that we were required to work under firm timing and budget constraints and we began with very limited data from which to base our selection of participants. Informal discussions with government representatives from each of the city’s districts were the primary means used to select our four project locations, and we were ultimately unable to speak with the district representative for Embakasi District. Therefore the locations we selected were our best estimate of those most highly populated by migrants to serve as a starting point for our investigation.

2

During the period of data collection, several bomb explosions took place within Eastleigh.

Second, we used a snowball sampling method, which means that our sample may not be representative of Nairobi's population at large, and our results are not generalizable beyond the four study locations. Further, some migrant participants were loosely connected to NOPE, and therefore the views expressed may be different from migrants who have no such connection to community organizations. Nonetheless, we believe that our project yielded important results that contribute to the continued discussion on how to best manage urban migrant healthcare in Nairobi, a city with a migrant population that is continuously expanding.

Third, we chose four locations of focus due in part to time and logistical constraints, and our findings are therefore specific to Mathare, Kayole, Majengo and South B areas of Nairobi. They can not necessarily be generalized to all migrants in all locations within Nairobi. We were unable to complete back-translation of transcripts for reasons also related to timing and budget, however the assistant who provided translation had extensive past experience translating for research purposes and we do not believe the quality of transcripts were compromised.

Lastly, we were limited by mobility restrictions due to threats of insecurity in Nairobi at the time of data collection. Therefore, several of the focus group discussions with migrants and Kenyan community members had to be conducted at the IOM regional office. This restriction may have influenced the group of individuals who chose to participate.

## DISCUSSION

Certain barriers were shared between migrants and Kenyan residents of informal settlements, suggesting the need for overall improvements to the healthcare system with respect to the four dimensions of access: availability, geographic accessibility, financial accessibility and acceptability of services (Peters et al., 2008). This is consistent with other studies on the health of urban populations, which indicate that poverty often overrides migration status in terms of health outcomes (Harpham, 2009). This is particularly relevant in Nairobi, where almost half the population lives below the poverty line and estimated measures of inequality are alarmingly high (Oxfam Great Britain, 2009). This finding also highlights the importance of employing a “spaces of vulnerability” approach that includes consideration of the potential strain on the host population when addressing issues pertaining to migrant health.

Nonetheless, there were barriers experienced exclusively by migrants, which related mostly to financial accessibility (cost discrepancies between migrants and Kenyans) and the acceptability of services (real or perceived discrimination, documentation requirements and language barriers), suggesting that urban migrants face unique and perhaps additional challenges in gaining access to an already limited healthcare system.

The reason for unequal fees being charged to migrants at public clinics was unclear. For the most vulnerable or poorest members of the population, whether migrants or Kenyans, any additional cost may make the difference between access to basic health services and no access at all (Peters et al., 2008). Attention should therefore be paid to ensuring that institutional policies are clearly laid out and that all employees of the public services, including registration staff, are implementing them fairly and equitably.

As a result of discrimination in healthcare settings – whether real or perceived - trust within the patient-provider relationship becomes jeopardized and can negatively impact future health-seeking behaviours of those who believe they were discriminated against (Ellis et al., 2008). Situations were described where perceived discrimination led to subsequent failure to be treated and avoidance of certain facilities. Not only might those few individuals fail to access the same service in the future, but due to the ease of information sharing within migrant communities, mistrust may be easily passed on to some or all of the local migrant community, causing more widely spread mistrust. This may be a particularly difficult scenario to address, since service providers may not be aware of the ways in which their behaviour may be interpreted.

Individuals with no proof of identity are vulnerable for a multitude of reasons (IOM, 2011b). These individuals are less likely to have access to employment, education and other rights. Participants reported the requirement to show identification to access certain services as a barrier and also feared harassment from the police on the way to or from healthcare facilities. Irregular migrants often do not possess proper documentation due to fear of presenting themselves to authorities, lack of knowledge about where to obtain it, or frustrations navigating a foreign administrative system (Jacobsen & Nichols, 2011). Organizations that require specific documentation for service provision, for administrative or other reasons, may inadvertently contribute to the vulnerability of the population that does not possess it (IOM, 2011b).

A large international body of evidence strongly suggests that language barriers in healthcare settings contribute to health disparities (Saha & Fernandez, 2007). When known language barriers exist, improving translation services can improve health outcomes and can be relatively cost-effective when considering the potential reduction in time per visit, reduction of unnecessary lab tests, and potential for earlier diagnoses to be made, therefore resulting in less need to seek services (Saha & Fernandez, 2007). With a growing number of Kenyan-born Somali and other Kenyan-born migrants or ethnic groups who could be included in recruitment for employment at health facilities, especially in migrant populated areas, the incorporation of translation services into public programming may be a strategic step forward.

## HEALTH PROGRAMMING RECOMMENDATIONS

This project has highlighted a primary need for improvements to healthcare access, particularly for migrants, with respect to financial accessibility and the overall acceptability of services. Stakeholders in migrant health should advocate for improvements in access to healthcare services that address the four pillars put forth by the World Health Assembly's resolution 61.17 on the health of migrants, which are: policy and legal frameworks, networks and partnerships, migrant-sensitive services and continued monitoring of migrant health through research.

### POLICY AND LEGAL FRAMEWORKS

- 1) Inclusion of migrants within the National Health Sector Strategic Plan (NHSSP), and associated sectoral plans, such as the upcoming fourth generation Kenya National AIDS and STI Strategic Plan (KNASP IV). This should be based on the Constitution of Kenya recognizes that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Migrants should also be mentioned with respect to specific health conditions to which they are vulnerable.
- 2) Advocate for increased allocation of funds to the public clinics in order to meet demands, reduce wait times and increase accessibility to primary care for all individuals in Nairobi who cannot afford to pay for private services.
- 3) Advocate for the adoption of policies that exert zero-tolerance for discrimination based on immigration status at healthcare facilities.
- 4) Develop a protocol that streamlines registration processes at city council clinics, which includes guidelines for registration and right to health services of non-nationals or those without formal documentation. For example, this could take the form of a memo from the ministry headquarters as was done by the South African Ministry.

### NETWORKS AND PARTNERSHIPS

- 1) Allied organizations, including the Government, should continue to collaborate and strategically organize their activities, paying particular attention to populations who may be especially vulnerable, including irregular migrants.
- 2) Related organizations should clearly delineate and communicate their target populations to the Government of Kenya (i.e. IOM irregular migrants; UNHCR persons of concern), ensuring that there is no duplication or do not inadvertently fail to include certain vulnerable individuals. In addition, related organizations should discuss and become aware of one another's activities, and be willing to make appropriate referrals for those who they cannot assist.

## **MIGRANT-SENSITIVE SERVICES**

- 1) Where there is need, public, private and NGO facilities should provide interpreters to help overcome language barriers, increase accessibility and acceptability of existing services for migrants. Hiring interpreters or multilingual healthcare professionals is a cost-effective strategy that is proven to successfully improve access to healthcare services for migrants.
- 2) Government regulations and professional practice standards should include cultural competence training programs in healthcare curricula that can effectively improve the attitudes and abilities of healthcare providers who work with migrant populations. Cultural competence refers to an ability to recognize and manage personal biases in such a way that the provision of care remains uninfluenced, as well as sensitization to the specific needs of the population being serviced.
- 3) Raise awareness among the migrant community through the use of migrant super mobilizers, who can be trained by healthcare providers to educate peers about migrant health issues, advertise migrant-friendly services and/or recruit potential clients of health services. It has been shown that information is readily shared among members of the migrant community making use of peer networks is an education is and effective and inexpensive way to disperse information.
- 4) Sensitize the community at large to the unique needs of migrants. When migrants are marginalized due to xenophobia, they are less likely to attain livelihoods that contribute to the social fabric of their community, and less able to access essential services such as healthcare. Research has shown that media education is among one of the components that contributes to reduced xenophobia.

## **MONITORING THROUGH STRATEGIC INFORMATION**

- 1) Inclusion of migration indicators such as country of birth, nationality and immigration status into national surveillance mechanisms such as the Census, the Kenya AIDS Indicator Survey (KAIS) and the Kenya Demographic and Health Survey (KDHS).
- 2) Collection of migration indicators such as country of birth and nationality as part of demographic data for health facilities in migrant populated areas. Individuals providing this information should be informed as to how such information will be used and how their confidentiality will be protected (e.g. any identifying data will be disassociated from any demographic data that may be used for research and operational purposes).
- 3) Continue to perform focused in-depth assessments of the factors that influence or discourage migrants from accessing individual healthcare services in key areas, such as those identified in this study.

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## APPENDIX ONE

Healthcare facilities accessed by migrants or reported to be accessible to migrants by service providers

### Mathare

1. Mathare North Health Clinic
2. Baraka Medical Centre
3. Lions Health Clinic
4. Mathare Psychiatric Hospital
5. MSF France Blue House HIV/TB Clinic
6. Eastleigh Maternity Clinic
7. Ngara City Council Clinic

\*Bona Hospital, \*Jama Hospital, \*St. Theresa's dispensary (maternal child healthcare)

### Kayole

8. Gertrude's Children's Hospital
  9. Mama Lucy Kibaki Hospital
  10. St. Mary's Hospital
- \*Kayole Health Centre, \*Divine Hospital

### Majengo

11. Pumwani Maternity Hospital
  12. Majengo City Council Clinic
  13. SWOP Majengo Clinic
- \*Eastleigh Sasa Centre

### South B

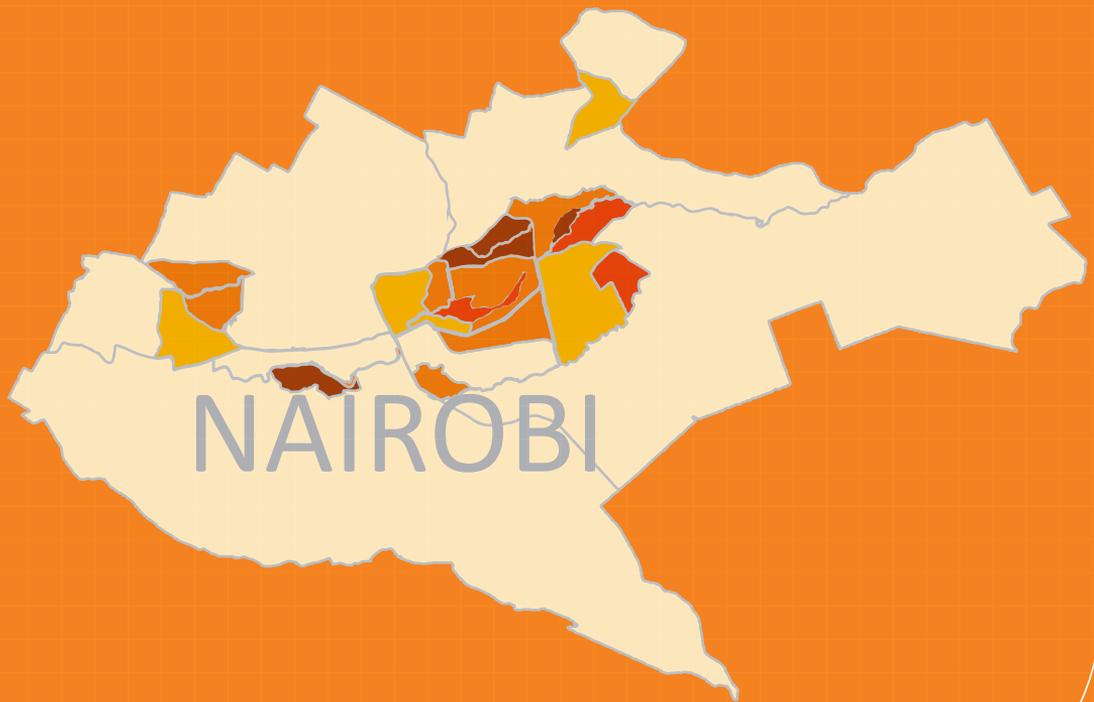
14. The Mater Hospital
  15. City Council of Nairobi Clinic
  16. Hallen Medical Clinic
  17. Kenyatta National Hospital
  18. Mbagathi District Hospital
- \*Industrial area Sasa Centre

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1 While some migrants do not pay income taxes, they contribute to other taxes such as VAT on their commodities purchased or consumed.

3 \*Indicates facilities that were mentioned by participants but were unable to be physically located by the researcher.





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IOM International Organization for Migration

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