



AN ANALYSIS OF MIGRATION HEALTH

IN KENYA



HEALTHY MIGRANTS IN HEALTHY COMMUNITIES

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COVER: A Kenyan woman weaves in and around trucks hustling for business in Busia, a border town sandwiched between Kenya and Uganda © IOM 2011 (Photo: C Hibbert)

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BACKGROUND

BACKGROUND

Objective

An Analysis of Migration Health in Kenya was commissioned by the Ministry of Public Health and Sanitation (MoPHS) and the International Organization for Migration (IOM) to provide an overview of the issue of migration health in Kenya. Information was derived from an extensive literature review and interviews with key informants, including the Government, United Nations agencies and non-governmental organizations.

The twin goals of Kenya's Second National Health Sector Strategic Plan are to reduce inequalities in health care and reverse the downward trend in health related impact and outcome indicators (Republic of Kenya, 2005a). By providing an analysis of migration health in Kenya, this report aims to stimulate discussion which will lead to decisive action from the Government and partners to ensure migrants may begin to enjoy more equitable access to health services. As migrants do not live in isolation, but rather in diverse communities, their health status has an impact on the community at-large. It is therefore the responsibility of – and in the best interest of – Kenya to cater for their basic health needs.

Migration can be defined as “a process of moving, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes the migration of refugees, displaced persons, uprooted people and economic migrants” (IOM, 2004).



Government child growth monitoring and immunization campaign at the Eastleigh Community Wellness Centre in Nairobi © 2011 (Photo: A. Corio)

OVERVIEW

Types of migrants in Kenya commonly include irregular migrants, asylum seekers, labour migrants, economic migrants, trafficked persons, urban migrants, commercial farm workers, internally displaced persons and refugees. Migrants also include mobile populations such as sex workers, pastoralists, fishing communities, transporters, civil servants, and uniformed personnel.

Irregular migrants are those who have entered a host country without legal authorization and/or who have overstayed their authorized entry, and as such, face unique vulnerabilities, notably those related to health. Often desperate to avoid accessing public services due to distrust or for fear of being deported or discriminated against, irregular migrants often only seek medical assistance when there is no other alternate course and tend to miss out on important promotive health measures such as immunizations, pregnancy care, and safe childbirth (IOM, 2009). Non-migrant friendly services also discourage patients by not catering for their cultural and language needs.

Push and pull factors: determinants and consequences of migration

The classic theory to explain why people migrate from one country to another is the “push and pull” factor: people migrate in response to push factors in their country of origin and/or pull factors in the country of destination. The push factors are generally negative, whilst the pull factors are largely positive (Potocky-Tripodi, 2002).

From the literature review and discussions with key informants, the following push and pull factors were uncovered:

Economic:

- Widening financial disparity and the growing need for young and relatively cheap labour drives people away in search of employment;
- Inequitable distribution of resources encourages people to search for equality and wealth elsewhere;
- Work requirements often necessitate travel for military officials, tradesmen, and transport workers;
- Kenya is a transit country for goods flowing to its landlocked neighbours, thus large numbers of mobile populations saturate its road and water transport corridors.

Socio-cultural:

- Poor schooling, social services, health care, family reunification and protection pushes people to move in search of new locales with improved facilities;
- Insufficient family support structures encourage individuals to migrate.

Natural, environmental and seasonality:

- Climate pushes pastoralists and cattle rustlers to move seasonally;
- Rural to urban migration can, in part, be attributed to the scarcity of natural resources; collapsing and contracting industries force people to move in search of a new trade;
- Natural disasters push those unable to cope or survive into safer locales or displacement camps;
- Outbreaks of disease compel people to move into non-susceptible regions.

Socio-political environment:

- Ongoing conflict in Somalia and Sudan and economic disparity in Ethiopia has resulted in a large number of migrants crossing Kenya's porous borders.

MIGRATION AS A SOCIAL DETERMINANT OF HEALTH

The definition of health

The 1946 constitution of the World Health Organization defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." "Migration health" refers to the well-being of migrants, mobile populations, their families, and communities affected by migration.

Migration as a social determinant of health

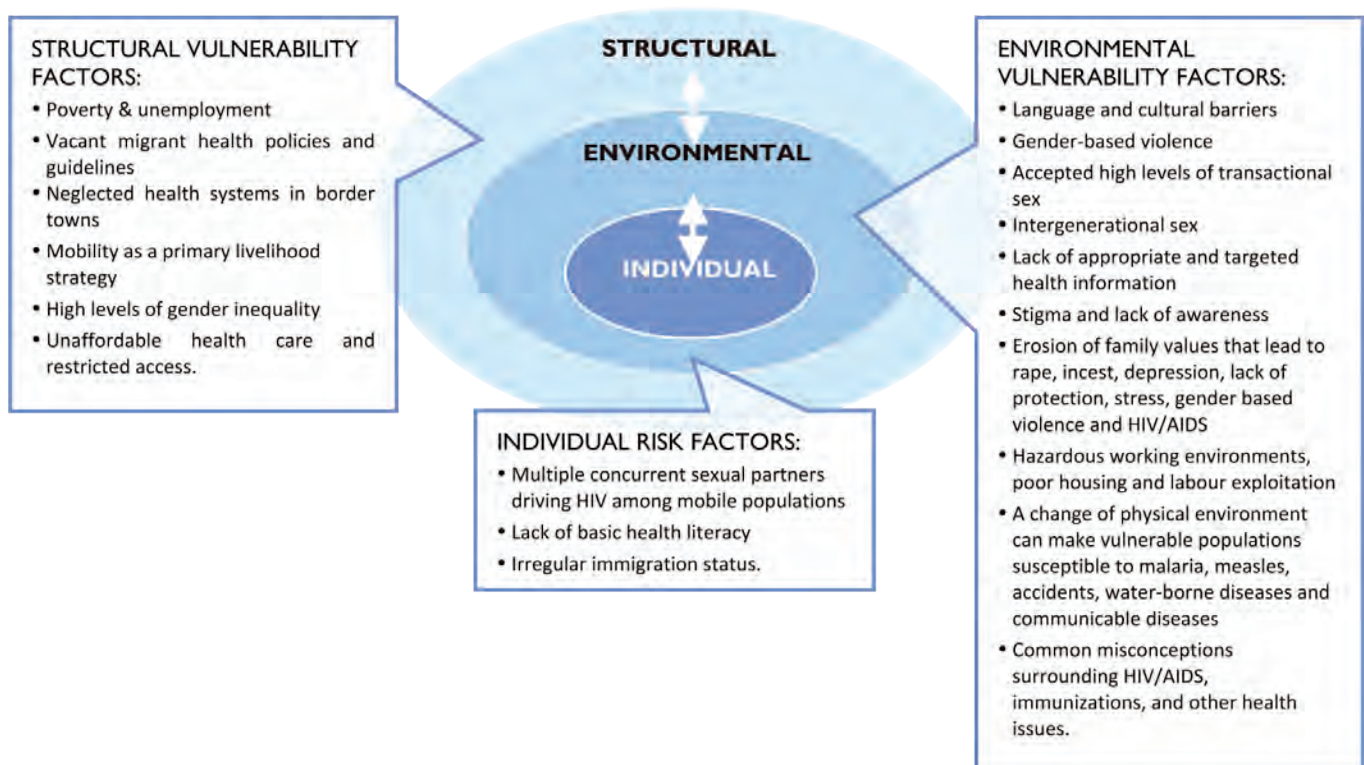
Although mobility is not of itself detrimental to health, it is a social determinant of health. The circumstance in which migration takes place, together with individual factors such as gender, language, immigration status, and culture, have a significant impact on health-related vulnerabilities and access to services (IOM, 2010a). The challenge for the Kenyan Government and partners is to understand these social determinants in order to improve the welfare of migrants and communities as a whole.

A multitude of sources indicate that a major challenge facing the health of migrants is access to appropriate services. Geographical accessibility, availability, affordability, and acceptability are the four major challenges to access, all of which must be addressed when reassessing Kenyan health policy.

MIGRATION AS A SOCIAL DETERMINANT OF HEALTH

So, why is it imperative that migrants gain access to health services in Kenya? Addressing the health needs of migrants not only improves their well-being, but it also safeguards the health of Kenyan host communities. In addition acceptance and integration of migrants contributes towards social and economic development. Furthermore, well-being is a fundamental human right which is recognized in the new Constitution.

With data captured from the literature review and interviews with key informants, the following were cited as major health-related vulnerabilities for migrants:



MIGRATION HEALTH CONCERNS IN KENYA

Tuberculosis and migration in Kenya

Kenya is among the world's top 22 high tuberculosis (TB) burden countries (WHO, 2010). A major reason for increased TB in Kenya in the past decade is the concurrent HIV epidemic, with 44 per cent co-infection in 2009.

The national TB strategy specifically highlights the need for strengthening programming to reach migrants in crowded urban centres, nomadic communities, migrant workers, and transport workers. These populations often face barriers to accessing information and services, including appropriate diagnosis. Treatment is complicated by the need to adhere to the regime for six months, and trans-border collaboration is therefore necessary. Surveillance needs to be strengthened in border areas (Republic of Kenya, 2010c).

IN FOCUS: Tuberculosis among urban migrants

Eastleigh, a large trading district in Nairobi, is home to thousands of migrants largely fleeing prolonged poverty and conflict in Ethiopia and Somalia. Eastleigh is also a major transit point between refugee camps, Somalia, and third countries to which migrants travel through legal and irregular channels.

A large proportion of the population lives in overcrowded, dark, and poorly ventilated apartment blocks, which are conducive to the spread of tuberculosis (TB).

The vast majority of migrants residing in Eastleigh are residing with irregular immigration status, and are hence deprived of basic health services due to fear or distrust of the authorities. Stigma, language barriers, and lack of health literacy are some of the social factors which discourage migrants from seeking appropriate diagnosis and treatment. For these reasons, private health facilities are preferred, and many are not licensed by the Government.

Due to their mobile nature, many migrants who start on TB treatment in Eastleigh do not complete their course of medication and often leave the district without adequate follow-up. This leads to further TB transmission and can result in drug resistance which carries higher mortality rates and burden to the health system.

A key issue in addressing this issue is to understand that migrants are not spreading TB, but rather, that they are unable to access the appropriate services for diagnosis and treatment.

"In my house, there are many, many people. The house rents are very high. These are hardships that cause the spread of various diseases. We also do not have money to access quality medical health care."

An urban migrant residing in Eastleigh, IOM 2011a

MIGRATION HEALTH CONCERNS IN KENYA

HIV and mobility in Kenya

The national HIV prevalence in Kenya was estimated at 7.4 per cent in 2007 (Republic of Kenya, 2008) and 6.3 per cent in 2009 (KNBS and ICF Macro, 2010). Mobility has often been falsely highlighted as a risk factor for HIV infection and it has occasionally been misconstrued that mobile populations carry HIV from higher to lower prevalence countries. The reality is, in order to spread the virus, an individual must first be infected with detectable levels of the virus, and then engage in risk behaviour, such as unprotected sex or drug injection. As with other health issues, it is the context of migration and how one is mobile that differentially impacts vulnerability.

Others have assumed that “vulnerable” populations must also have higher HIV prevalence. A synthesis of seven sub-Saharan African countries found refugees in all but one camp setting to have a prevalence which was comparatively much lower than in surrounding host communities. A gradual rise in prevalence in camps was attributed to refugees engaging in risk behaviour with members of host communities (Spiegel et al, 2007). IOM has likewise found that HIV prevalence among refugees and migrants undergoing migration health assessments in Nairobi is just a small fraction of the prevalence of Nairobi, and more or less on par with the prevalence in countries of origin. The post-conflict setting, however, may see a precipitous rise in HIV prevalence as may be the case in northern Uganda, Somaliland, and parts of southern Sudan.

While data is not sufficient to identify a link between population displacement in the emergency context and increased HIV transmission, Kenya experienced major breakdowns in the provision of HIV-related services in the 2008 election aftermath. Guidelines and capacities are required at all levels to prevent similar systemic breakdowns in future emergencies.

IN FOCUS: Risky sexual behaviour along transport corridors in East Africa

Most-at-risk populations, such as female sex workers and their clients, account for an estimated 14 per cent of all new infections. This is a substantial decrease from the early years of the epidemic when female sex worker and truck drivers were seen as core population groups; however, vulnerable groups along transport corridors remain substantial contributors of new infections and remain among the most important populations not adequately covered by the prevention efforts (NACC, 2009a). A 2005 study estimated that along the Mombasa-Kampala highway 3,200 to 4,148 new HIV infections occur every year (Morris & Ferguson, 2006).

In ports, cities, border crossings, and truck stops, income disparities between “mobile men with money” and women of lower economic status fuels a market for sex (IOM & UAC, 2008). As many of these relationships evolve into

“Sometimes you find that those who are not HIV positive are given support and you who is positive do not benefit. This is why if her husband tries to seduce me I will not refuse because they benefit from the support which I am supposed to get, and I will say ‘to hell let them die with me.’”

HIV positive female sex worker, Salgaa (IOM & NACC, 2010)

MIGRATION HEALTH CONCERNS IN KENYA

long-term partnerships, condom use remains low. Many men and women in these locations have several different sexual partners, there is high potential of spreading the virus, especially among those who are newly infected and thus have much higher levels of virus in their bodies (Halperin & Epstein, 2007).

The epidemiology of HIV along transport corridors is not restricted to truck drivers and sex workers. As highlighted in Figure One, a female sex worker engages with a diverse clientele, of which only about 30 per cent are trucker drivers (Republic of Kenya, 2005b). A similar 2008 IOM study on the Kampala-Juba corridor showed similar findings.

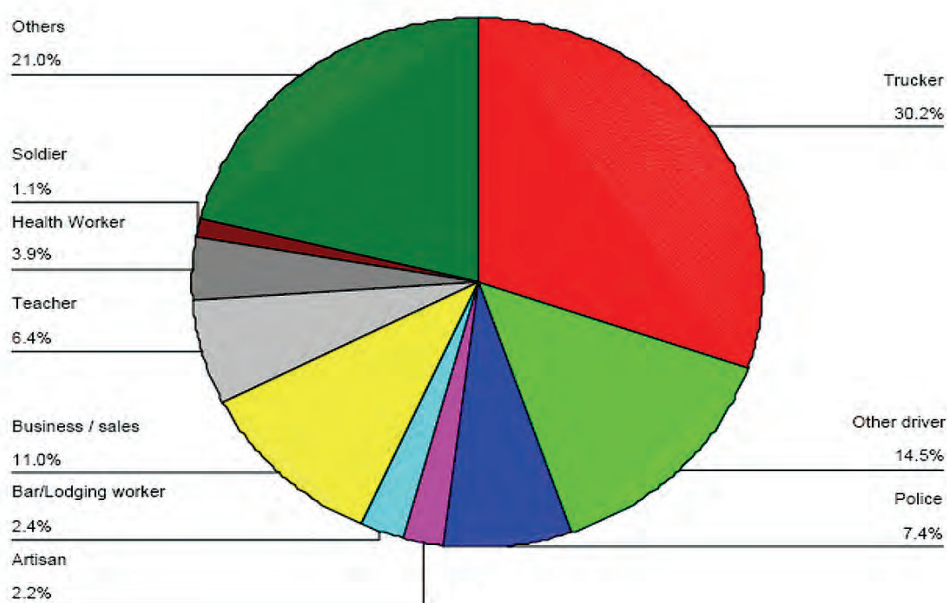


Figure One: Clientele of female sex workers along the Mombasa – Kampala corridor, data gathered using 28-day FSW diaries (Republic of Kenya, 2005b)

The lack of effective HIV prevention interventions in spaces of vulnerability along Kenya's major transport corridors is cause for alarm. A 2010 response analysis of five major sites along the corridor from Mombasa to Busia witnessed no instance of behavioural interventions though nearly 30 agencies claimed to run such programmes. Over 60 per cent of 600 truckers and female sex workers interviewed reported having never received information on HIV/AIDS. In spite of working in close proximity, no instance of collaboration between agencies was reported (IOM & NACC, 2010). Clinical services, including HIV Counselling and Testing (HCT), are not sufficiently accessible.

The scenario is akin to that of a tug-of-war with each agency pulling the rope in a different direction and the response moving nowhere. A national strategy has yet to be developed to guide implementing partners on a common approach that can be brought to scale.

MIGRATION HEALTH CONCERNS IN KENYA

Reproductive health and migration in Kenya

The reproductive health needs of refugees living in camp settlements are well documented; however, significant gaps remain in understanding the reproductive health needs of other mobile populations, whether irregular migrants, pastoralists, or others (Hynes, Sheik, Wilson, & Spiegel, 2002). Irregular migrants and female sex workers are often overlooked in regards to health promotion activities, including access to family planning, prenatal, delivery, and early childhood health care. This leads to such issues as maternal mortality and chronic measles outbreaks in urban slums due to lack of coverage by vaccination campaigns.

A pilot study found substantial differences in access to maternal and child health services between migrant and Kenyan women in the community of Eastleigh. Most notable were the differences in antenatal care, labour and delivery, contraception and breastfeeding. Following up on the findings using informal discussions, it was found that despite a general consensus on the importance of accessing maternal-child health care, migrant women cited numerous barriers, including cost, language barriers and religious beliefs, and a lack of trust in available services due to health care worker attitudes and quality of services within the facilities (IOM & McGill, 2011).

Additionally, appropriate service delivery is vital, especially with the current push among the Government and donor community on utilizing maternal child health services as a conduit to access female sex workers and vulnerable women with HIV prevention programming, which is an approach that the International Organization for Migration has long advocated for.

IN FOCUS: reproductive health among pastoralists in Northern Kenya

Northern Kenya has one of the highest maternal mortality rates in the country, estimated at 1,000 – 1,300 deaths per 100,000 live births, compared to 530 per 100,000 live births nationally. As one of the poorest, remotest regions in Kenya, malnutrition is rampant and access to safe drinking water and improved toilet facilities is non-existent for the majority of pastoralists (Republic of Kenya, 2008; IOM/IGAD, 2009).

The 2009 drought pushed malnutrition levels to 12 per cent in the Garissa district, and 15 per cent in the Baringo district. With drought hitting Kenya hard in 2011, food instability, child undernutrition and maternal mortality is currently a looming national disaster. Remote pastoralist communities will invariably be affected; maternal health facilities are severely lacking and pastoralists regularly have to travel long distances to reach the nearest health facility.

Moreover, there is a reluctance to seek services in health facilities. Pastoralists in Kenya tend to prefer traditional health care providers over modern medical

MIGRATION HEALTH CONCERNS IN KENYA

practices (IOM/IGAD, 2009), as health facilities are perceived as less sufficient because they are too far away, lack the necessary services and equipment and services offered are not adapted to a mobile lifestyle. An unfavourable attitude adopted by health workers and no money to pay for treatment were also cited as reasons to shun existing health services (IOM/IGAD, 2009).

Improved access for pastoralist communities must be scaled-up through outreach programmes that are available to remote populations in a way that is tailored to seasonal mobility patterns.

Additional health concerns facing migrants in Kenya

Malaria is the leading cause of morbidity and mortality in Kenya (Republic of Kenya, 2008). Migrants and mobile populations are particularly vulnerable as treated mosquito nets remain elusive and health services are lacking. A report by Mosca, Wagacha, Aketch, Stuckey and Gushulak (2000) indicates that a bulk of migrants who resettle to third countries originate from rural refugee camps where malaria transmission may be hyper-endemic. Several studies have also highlighted that malaria is the top health concern of mobile populations such as truckers, who sleep in or under their vehicles without access to mosquito nets (IOM & GLIA, 2006).

The informal private sector has proliferated since its liberalization during the late 1980s. Much like the majority of Kenyans, irregular migrants rely on the private sector and it can be assumed that they might not receive appropriate diagnosis or treatment as they self-medicate with shop-bought anti-pyretics and anti-malarials that may not meet national standards for quality and effectiveness (Republic of Kenya, 2001).

Measles and other vaccine-preventable infections: Kenya has experienced multiple outbreaks of measles over the last decade despite the existence of an effective and affordable vaccine. In 2005, 2007 and 2009 outbreaks began with unvaccinated migrants, many of whom come from nations with historically low immunization coverage and minimal health care delivery infrastructure. Migrants frequently distrust and have misconceptions surrounding vaccinations; these need to be better understood and messaging developed to better promote immunization uptake in migrant communities. The potential re-emergence of polio is another particular concern in migrant communities.

Occupational health: Long hours, loneliness and harsh, dirty living and working environments often expose labour migrants to risks such as occupational injury, gastrointestinal issues, tuberculosis, and HIV risk-behaviour.

“There was no means to take her to a health centre and she had been in labour for four days. The bleeding did not stop after delivering so we just watched as she continuously bled to death.”

Pastoralist mother, Turkana, IOM 2011a

MIGRATION HEALTH CONCERNS IN KENYA

Psychosocial health: Those who migrate clandestinely, or fall into the hands of traffickers and end up in exploitative situations, are disproportionately affected by psychosocial health. Conflict and displacement also incite a huge emotional burden for those affected.

POLICY ANALYSIS

The Bill of Rights which is anchored in the new 2010 Constitution of Kenya recognizes that it is a fundamental duty of the State to observe, respect, protect, promote, and fulfil the rights and fundamental freedoms of all people in Kenya. It also asserts that every person in Kenya has the right to the highest attainable standard of health.

However, Kenya still has a long way to go before this is realized. Logistical challenges to reach migrants and mobile populations, top-down health systems that fail to contextualize services for vulnerable populations are all challenges that can, and must, be addressed.

Interviews with key informants highlight a growing concern that the Kenyan Government's mandate for securing a healthy population does not commensurate with its lack of initiative in reducing health disparities in communities affected by migration and population mobility. The prioritization of migrant health should be embedded within all Kenyan Ministries. In Kenya, assistance provided to internal migrants is implemented by the Ministry of State for Special Programmes, which in most cases responds to disasters, with minimal preventive or health promotion programmes in place. These programmes protecting migrants cannot be sidelined, and instead should be ingrained within national action plans and strategies.

How can we prioritize migrants with a stretched health care system that even Kenyans are not accessing? This is a common question argued in many policy forums; however, communicable diseases do not respect borders and migrants live in communities with Kenyans. It is only through partnership, led by the Government of Kenya, that we can provide health care for all who reside within its borders.

THE WAY FORWARD

As Kenya progresses towards Vision 2030, it will continue to be a prime destination for its East African neighbours as a regional economic hub. Migrants will continue to come to Kenya throughout this forthcoming economic expansion, and as a result of increased movement of trade goods and people within spaces of vulnerability, there will inevitably be an impact on the health of communities throughout Kenya.

Migrant and mobile populations access to essential health information and services is often problematic. With the potential for increased numbers of migrants, it is essential that policymakers and programme managers gain a better understanding of the various typologies of migrants and their underlying health drivers, so that the national health package can be tailored to their specific needs.

Achieving the health Millennium Development Goals, the challenges faced by the Government of Kenya and its partners is to ensure equitable access to health and social services within the context of increasing diversity and disparities. At the same time, long-standing programming gaps related to migrants and mobile populations have yet to be adequately addressed. In order to meet these demands, strengthened partnerships are required among stakeholders within Kenya, with the donor community, as well as with neighbouring countries.

National policy in regards to migrant health must be as bold as the Constitution and Bill of Rights, where the rights of migrants are protected. Utilizing such a lens it is easily understood that Kenya can adopt an approach where healthy migrants live in healthy communities. To achieve such a goal, it is imperative that we come to a common consensus on the inclusion of migration health in general health promotion and vertical health strategies in Kenya. Specifically this could include the formation of a National Forum for Migration Health chaired by the Government of Kenya, to strengthen coordination among stakeholders and to draw a Common Action Plan (CAP) for migration health.

RECOMMENDATIONS

The Government, with support from partners, should take leadership on:

1. Establishing an institutional reference point for health issues relating to migrants and mobile populations, for example, a dedicated unit within the Ministry of Health;
2. Reviewing national strategies and guidelines and ensuring that mechanisms are in place to reduce health disparities faced by migrants and mobile populations;
3. Facilitating, providing, and promoting equitable access to comprehensive available, affordable and non-discriminatory health services. This should include health promotion, disease prevention, and care for migrants;
4. Offering health services in target areas where migrants are present and where they can be accessed, for example, cross-border communities, hot spots along transport corridors, fishing villages, plantations, and urban settlements;
5. Providing basic health services to migrants, regardless of immigration status, as a public health priority;
6. Making services more migrant-friendly through such means as engaging migrant community leaders and employing staff who speak migrant languages;
7. Developing national strategies to address specific issues, for instance, on scaling-up one national framework on preventing HIV along transport corridors;
8. Sensitizing and building capacity of police, health care providers, and gatekeepers (including security guards at clinics) to the importance of ensuring “health for all” and for meeting the specific needs of migrants;
9. Strengthen the documentation of health issues facing migrants and mobile populations, including qualitative research on access and acceptability, disaggregating surveillance data to identify migration-related data, and including migration-related indicators in Demographic and Health Surveys and related activities;
10. Expanding funding and research capacity for those investigating topics within the field of migration health;

RECOMMENDATIONS

11. Addressing the environmental and structural factors impacting the health of migrants, in addition to individual risk factors;
12. Strengthening the coordination of health issues that face migrants among stakeholders within communities, countries, and between countries;
13. As feasible, strengthening collaboration on health programming between places of origin, transit, and destination;
14. Harmonizing treatment protocols between countries and establish trans-border referral mechanisms for issues including tuberculosis, HIV/AIDS, and maternal-child health;
15. Develop a Regional Disaster Management Plan to deal with pandemics, breakdown in HIV/AIDS programming, and other disasters that affect migrants and displaced populations.



Whole families can live in just one room in Eastleigh
© 2011 Silverscreen Pictures

RECOMMENDATIONS

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Jamilla Namatou stands waiting for clients in the border town of Busia.
“If men have HIV, then they see no reason to wear a condom,” she says © IOM 2011 (Photo: Celeste Hibbert)





HEALTHY MIGRANTS IN HEALTHY COMMUNITIES



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