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

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

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

ABSTRACT

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

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1. Background

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

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

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

1.1. Migration health in Nairobi

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

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

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

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

1.2. Overview of relevant migrant health policy in Kenya

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

1.3. Overview of the healthcare system in Kenya

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

Private facilities are abundant in Nairobi and range from small clinics to hospitals fully equipped with operating theaters and specialized care units. The major drawback of private facilities is that their costs are high in comparison to public services and therefore restrict access by those who cannot afford them (Turin, 2010). Additionally, some non-governmental organizations (NGO), community-based organizations (CBO) and faith-based organizations (FBO) offer certain healthcare services and health-related assistance. These services are usually provided free of charge (Mapendo International, 2010).

Health programming that specifically targets urban migrants is provided by the UNHCR and partners. In some cases, it is also provided by NGO and refugee protection agencies that operate in Nairobi, however, the latter usually require registration with the UNHCR or Department of Refugee Affairs. The IOM Eastleigh Community Wellness Centre offers health services to migrants and host community members living in the Eastleigh area of Nairobi, irrespective of immigration status (IOM, 2010).

1.4. Project purpose

The purpose of this project was to explore barriers to accessing healthcare experienced by urban migrants and Kenyans living in areas considered to be spaces of vulnerability in Nairobi.

2. Methods

This project is the result of a continuing partnership between the McGill University Ingram School of Nursing and the IOM Migration Health Division in Nairobi, Kenya. The study took place between September and December 2012. IOM provided logistical support for the transportation of one of the authors and the transportation of participants to and from focus groups, as well as the remuneration for a research assistant who helped with data transcription and translation. Ethical approval was obtained from the McGill University Faculty of Medicine's Institutional Review Board and community approval was obtained from leaders in each of the study locations prior to initiation of data collection. We sought consent from all participants before each interview, and with a translator present (when appropriate) to ensure participation was fully informed and voluntary. Participants did not receive any compensation for their participation.

We employed a qualitative descriptive design. Sandelowski (2000) recommends this research design when aiming to increase 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 dispersal of the migrant population in Nairobi, qualitative descriptive methodology provided a systematic yet flexible way to identify and understand the inside perspectives of participants most knowledgeable about our research topic.

2.1. Data collection

Nairobi is divided into nine administrative districts. We first contacted a government representative from each of the nine districts and asked them to participate in informal discussions with us. One government representative (Embakasi district) 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 literature and document review of publications selected for their content relating to migrant or refugee health in Nairobi. Four specific locations (excluding Eastleigh) were cited most often by government representatives and in the literature as being significantly populated by migrants and were consequently selected for further study: Mathare, Kayole, Majengo and South B/South C (Beguy et al., 2010; Campbell, 2006; Federation of Women Lawyers-Kenya and The Global Alliance Against Traffic in Women, 2010; IOM, 2011a; IOM, 2011c; Pavanello et al., 2010; UN-HABITAT, 2006; UNHCR and The Danish Refugee Council, 2012).

Participants from the four selected locations were purposively sampled in collaboration with the National Organisation for Peer Educators (NOPE), due to this organization's involvement and positive reputation within the community. 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 and Beck, 2008). As a result of the non-random sampling procedures used, our results may not be generalizable to other areas in Nairobi. However, snowball sampling was the only option that allowed for sufficient participation within our time and resource constraints, and we do not believe it compromised the goal of obtaining initial data about the research topic in order to form the basis for further, more focused research and service delivery in the future.

In each of the four study locations, one government program 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

Table 1
Inclusion criteria by participant group.

Participant group	Inclusion criteria	Exclusion criteria
Government representative	- Can speak and understand English or Kiswahili - Holds a position with the Government of Kenya (Ministry of Public Health and Sanitation or the Ministry of Health Services will be preferred) - 18 years or older	- Declined consent - Major hearing or cognitive impairment that prevents giving fully informed consent
Health service providers	- Can speak and understand English or Kiswahili - Has held a position within a public, private, faith-based or NGO health service facility in Nairobi for at least 1 month - 18 years or older	
Member of migrant community	- Self-identifies as a migrant - 18 years or older	
Member of host community	- Can speak English or Kiswahili - Born in Kenya - 18 years or older	

recruited with the assistance of a willing community leader from each location, identified through NOPE or a partnering organization, and instructed on the principles of informed consent. 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. This individual spoke to prospective participants with whom they had previous knowledge regarding migration status. These participants were then asked to recruit a variety of further participants (not family or close neighbors) until at least 4–6 people from that location agreed to participate. Inclusion and exclusion criteria for each participant group are outlined in Table 1. Three service providers who were initially contacted declined their participation without disclosing their reasons for doing so.

One-on-one semi-structured interviews were conducted in English with all government program representatives (n = 3) and service providers (n = 8) who participated. Both men and women were represented among government representatives and service providers. In all cases, government program representatives were the same individuals who took part in initial informal discussions in their respective locations (n = 8). Interviews were held at a time and place of the participant's convenience and lasted 25–60 min. A 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 their location.

Eight focus group discussions were held. These included two separately held focus groups with migrant and Kenyan community members from each location: 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). Both men and women were represented in all focus group discussions, with the exception of the two Majengo focus groups, (both migrant and Kenyan groups) for which all participants were women, and the Mathare migrant group, for which all participants were men. All focus group participants fell between the approximate ages of 18–65 years. When necessary, a translator was present to permit participants to respond in Kiswahili if desired. Migrants were not asked for identification in order to avoid mistrust or suspicion regarding the project. Immigration status was only disclosed within the focus group discussions and only by those who did so voluntarily. Migrant categories that were represented included refugees, asylum-seekers and irregular migrants. The countries of origin of migrants that were voluntarily disclosed were: Democratic Republic of Congo, Ivory Coast, Tanzania, Uganda and Rwanda, but participants were not recruited based on nationality. Focus group discussions lasted 40–70 min 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.

2.2. Data analysis

Verbatim interview and focus group transcripts were translated to English from Kiswahili (where necessary) and transcribed. All of the transcripts were read several times, 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 topic that was being addressed. Interpretive analysis followed, where conceptual links were established and triangulated between participant groups within their respective locations. Verification of coding was confirmed by a second research team member.

3. Results

All participants — government officials, service providers, migrants and Kenyans — identified barriers that restricted, or had the potential to restrict access to healthcare services in their location. Each barrier fell under one of the four broader dimensions of access outlined by the conceptual framework described by Peters et al. (2008): availability (waiting times, drug availability); geographic accessibility (lack of transportation, threat of harassment en route); financial accessibility (affordability, cost discrepancies between migrants and Kenyans) and acceptability (real or perceived discrimination, documentation requirements, and language barriers.) Interestingly, migrants and Kenyans described many of the same barriers relating to availability and geographic accessibility, whereas the particular barriers relating to financial accessibility were different between migrants and Kenyans, and those relating to acceptability of services were reported almost exclusively by migrants.

3.1. Availability

Long waiting times 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".

3.2. Geographic accessibility

In each of the project locations, the majority of participants from all participant groups − migrants, Kenyans, service providers and government representatives − could provide several names and sites of public and private facilities that were geographically accessible to them. Two exceptions reported by both migrants and Kenyans, particularly in Mathare and Kayole, were maternity services and emergency services. Participants highlighted the dangers for women, particularly at night, associated with "climbing out of the slum" once they began to experience labor contractions and the absence of any transportation or ambulance services due to lack of roads or poor conditions of the roads.

A further barrier relating to geographic accessibility, but reported by migrants only, was fear of arrest or harassment by the police while traveling to or returning from a hospital or clinic, especially for irregular migrants. Migrants described neighbors who 'hide in the slums and don't want to come out'. One participant described avoiding travel to access services for the same reason:

> "You might get policeman on the street and they will ask you to produce ID and if you don't have you will be arrested and that is on your way to hospital or back from the hospital." − migrant

However, in some cases, like the one below, possession of an official UNHCR refugee mandate was reported to deter difficulties with police: "… with the mandate [the police] give you some kind of respect. But without the mandate they disturb you." − migrant.

3.3. Financial accessibility

Affordability was reported to be an issue for several participants, irrespective of immigration status. Both migrants and some Kenyans reported not being able to afford private services, and several migrants were unable to afford the 20 ksh (approx. 0.25 USD) registration fee for public services. Participants who could afford them reported a tendency to favor the private services despite their

higher costs, stating that they would rather spend the extra money "out-of-pocket" than be "treated half" at the public facilities.

Although affordability was noted by both migrant and Kenyan participant groups, there was also a reported requirement for migrants to pay a higher fee for services at the public clinics. This cost differential was described not only by migrants, who were required to pay them, but also by Kenyans and by service providers who were not employed at public clinics.

"I know that some clinics they make refugees pay more." – NGO service provider

"It's not 20 shillings we are asked to pay maybe 150, 200, 300, but not 20. That is for Kenyans." - migrant

"Yes [migrants] would be able to access the public services, just at a premium." - NGO service provider

"Yeah they think 'cause we migrants we have all this money or like, we have support from the UN, they see us going maybe to town for an appointment and they think we rich." - migrant

There was a clear discord between the above statements and what government representatives, service providers from public clinics, and Kenyan participants reported:

"If you can pay the 20 shilling fee then we have no restrictions for migrants so they can access healthcare." - public service provider

"[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." - government representative

Interviewer: "Where is it possible for people in the community to seek medical care?

Respondent: "Me I think the public clinics because private ones are quite expensive. Yeah because you can go and register and it's 20 shillings." – Kenyan participant

When migrants were asked if they were offered a rationale for having to pay more than the 20 shilling registration fee at public clinics, most stated that they "had never questioned it" and one individual explained that he was "not in a position to do so". No service providers or government representatives referred to any policy that required migrants to pay an additional fee for services. The cause of the discrepancy was therefore unclear, but it should be noted that none of the service providers who participated in this project were responsible for the collection or handling of fees at their respective clinics and no administrative or clerical staff were interviewed due to time and logistical constraints.

The same discrepancy was not evident for services offered by the private sector. Participants described the superiority of private services with respect to both quality and equitability, albeit more expensive overall.

3.4. Acceptability

Acceptability refers to the responsiveness of healthcare services and their providers to the social and cultural norms in the communities they service (Peters et al., 2008). Three main themes related to poor acceptability were described by migrants and service providers, whereas the same themes were not reported by Kenyans. These were real or perceived discrimination, documentation requirements and language barriers.

Real or perceived discrimination. As previously noted, lack of available drugs, primarily at public facilities was reported by government representatives, service providers, Kenyans and migrants alike. Interestingly, Kenyans tended to report this as a widespread challenge related to system shortages, whereas migrants tended to describe it as the provider purposely withholding drugs for treatment. Service providers and several Kenyans commented that 'clients are given whatever is there' and 'usually they don't have enough', or that medication was '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:

"When we visit the public 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 eventual 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 her reluctance to seek future services from that particular facility:

"Yes like me 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 but this one was charged and she had to look for help from well-wishers in order to pay for the bill and I avoid [that] hospital just because of that." – migrant

Documentation requirements. Participants did not necessarily have to show documentation to access services at public 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 it did not necessarily have to be Kenyan. Therefore documentation requirements at *public* clinics was not a significant barrier for migrants or Kenyans, however, when foreign identification was used, migrants reported being charged higher fees.

Several organizations that operate in Nairobi were described as providing various forms of support including healthcare to refugees and asylum-seekers, but not to irregular migrants. Irregular migrants reported being unable to access the services of certain NGO and CBOs as a result of the requirement to provide official documentation upon registration. Participants generally seemed to perceive this barrier as driven by administrative processes. For example, one service provider described,

"…we request documentation and the standard identification in Kenya is an identity card or a passport or something." – NGO service provider

" …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

Language barriers. Government representatives and service providers considered language as a barrier for providing services to migrants, particularly in Majengo and Mathare which are in close proximity to Eastleigh, a location known for its large Somali population.

"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

"We have no restrictions for migrants so they can access healthcare. The only limitation would be language barrier." — government representative

Migrants who participated also spoke of language barriers as a factor that would limit access to services for members of their respective migrant communities; however, all of the actual participants of the project spoke either Kiswahili or English and therefore did not report language as being an issue they had encountered themselves.

4. Discussion

While this project primarily addresses barriers to accessing healthcare services, we recognize that access to healthcare is just one of many factors surrounding the health of populations that interact to produce unfavorable conditions and subsequent vulnerabilities to ill health. Poverty, poor sanitation, crowded living conditions, social exclusion and limited opportunities for education and employment are among the factors that also impact the health of the urban poor (Harpham, 2009; Marmot, 2005). These issues and the need for approaches that address them have not been overlooked. Rather, we chose to focus qualitatively on barriers to access because examples of successful interventions aimed at improving access to healthcare in urban environments exist (Peters et al., 2008) and because it is believed that understanding the *details* of the lives of vulnerable populations is necessary for the formulation of policy and programmatic response that appropriately addresses the identified concerns (Harpham, 2009).

Our project revealed that Kenyan participants shared many of the same barriers that migrants did, particularly those related to availability, geographic accessibility, and to some degree financial accessibility. This finding is consistent with other studies on the health of the urban poor, which indicate that poverty often overrides immigration status in terms of health outcomes (Harpham, 2009). In other words, and perhaps not surprisingly, being poor may be more harmful to health than being a migrant. 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).

Our results suggest that overall, the availability and geographic accessibility of healthcare services are a shared concern for migrant and Kenyan residents of our study locations. Of particular concern were waiting times and drug availability at public-run facilities, suggesting that the government system is largely overburdened. Additionally, a need for emergency and maternity services was identified by all participant groups.

Barriers experienced exclusively by migrants were also described, and 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. Many of the barriers relating

to acceptability of services were closely in line with those identified in previous research with migrant women in Eastleigh, Nairobi (IOM, 2011a). Further discussion of the barriers that were unique for migrants and their implications for stakeholders of migrant health issues follow below.

4.1. Cost discrepancies between migrants and Kenyans

The reason for inequitable fees being charged to migrants at public clinics was unclear. One possible alternate explanation for this finding could be conflation between public and private clinics among migrants who are unfamiliar with the Kenyan healthcare system, however we verified participant understanding of private versus public/city-council clinics wherever possible, and higher user fees for migrants were also described by migrants in the past (IOM, 2011a).

The evidence regarding fees for health services in low- and middle-income countries clearly demonstrates that increases in user fees leads to decreased utilization, and that this tends to disproportionately affect the poorest members of a population (Peters et al., 2008). Lack of financial resources creates barriers to accessing care, but the relationship also runs in reverse. When financial barriers that limit access to care are present, health status deteriorates and results in lost income, as well as higher health costs for delayed, more advanced treatment. While the literature suggests that poverty may be a better indicator of health risk than immigration status, the unexpected finding that migrants are being charged unequal user-fees suggests that in our four study locations, immigration status is linked to decreased financial accessibility. Strategic policy-level interventions based on further focused research are required to improve the financial accessibility of healthcare to the population of Nairobi, with particular focus on its vulnerable members.

4.2. Real or perceived discrimination

A second barrier to healthcare access described by migrant participants exclusively was real or perceived discrimination. Discrimination, described as 'harsh treatment' was also an issue brought forth by migrant women in Eastleigh (IOM, 2011a). It has become evident that rising xenophobia, racism, and discrimination are increasingly prevalent in countries that receive a large number of migrants, whether through official or unofficial means (Crush and Ramachandran, 2010). Rising xenophobic sentiments in developing countries are thought to be the result of a perceived yet unrealistic threat to scarce resources, and a failure of governments to recognize the human development potential that can result from well-managed migration, even between low-income countries (Crush and Ramachandran, 2010). Xenophobia toward migrants manifests itself as hostility toward, or even abuse and exploitation of migrants by employers, authorities, service providers or neighbors belonging to the host community. Migrants who have endured severe mistreatment or who have migrated due to traumatic circumstances may be more inclined to perceive xenophobic or discriminatory transgressions against them (Phinney et al., 1998).

Discrimination in healthcare, whether it is real or perceived, jeopardizes the necessary trust within the patient—provider relationship and can negatively impact the future health-seeking behaviors of those who believe they were discriminated against (Ellis et al., 2008). It is unknown whether the healthcare providers in the scenarios described by participants intended to exhibit discriminatory behavior; however the underlying motives do not change the outcome. Perceived discrimination led to failure to be treated and the subsequent avoidance of certain healthcare facilities. Not only might those individuals fail to access the same service in the

future, but due to the ease of interpersonal communication within migrant communities, mistrust may be easily passed on to some or all of the local migrant community, causing more widely spread mistrust. The inclusion of cultural competence training programs in government regulations and professional practice standards has been shown to effectively improve the abilities of healthcare providers to meet the needs of a diverse patient population and improve patient satisfaction (Beach et al., 2005). Cultural competence refers to an ability to identify and reflect on personal biases and the ability to adopt a constant awareness of how to manage personal biases so that the provision of care remains uninfluenced (National School of Public Health, 2010; Registered Nurses' Association of Ontario, 2007). It also includes sensitization of the public to the needs of the particular community being serviced (Registered Nurses' Association of Ontario, 2007). NGOs and other stakeholders can bring xenophobia to the attention of policy-makers, the media and the public, so that the human rights of migrants with respect to accessing healthcare are made well-known (Crush and Tawodzera, 2011).

From the results of our study, it appears that a general recognition of migrants' rights to access healthcare and more specifically here, the provision of more detailed information regarding treatment and drug availability is an unmet need of the migrant community. If service providers are able to patiently and thoroughly describe the reasons for limitations of the services they can offer, migrants may be less likely to perceive discrimination where it does not exist, particularly among those who are accustomed to receiving all of their medical care in one central location, such as in refugee camps.

4.3. Documentation requirements

Two separate issues arise with respect to documentation requirements for migrants. The first is where and how to obtain identification for individuals who do not possess it. The second is differential treatment based on the presentation of a refugee/asylum-seeker mandate or other foreign identification. Individuals with no proof of identity are vulnerable for a multitude of reasons (IOM, 2011b). They are less likely to have access to employment, education and also forms of protection and support, such as healthcare. Participants reported a requirement to present proof of identification in order to access certain healthcare services as a barrier and also feared harassment from the police on the way to or from healthcare facilities. Interestingly, proof of identification was not an issue brought forth in past research in Eastleigh, perhaps because its tightly knit community would promote the ability for newcomers to obtain information about the attainment of appropriate documentation. It may also be unnecessary to possess identification in order to use private clinics within Eastleigh. Migrant women in Eastleigh did, however, echo the barrier that the threat of harassment creates for accessing healthcare outside of the community.

Governments, international agencies and NGOs 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). Our results suggest that irregular migrants were excluded from some of the services being provided to refugees and asylum-seekers. Often, the reasons for irregular migrants not possessing proper documentation are related to fear of presenting themselves to authorities, lack of knowledge about where to obtain it, or frustrations navigating a foreign administrative system (Jacobsen and Nichols, 2011). At minimum, organizations in Nairobi should clearly delineate who they can assist (e.g. refugees and asylum-seekers), and who they cannot (e.g. irregular migrants), so that related organizations can

coordinate their efforts and prevent certain groups of people from falling through the cracks of the system. Organizations should also be willing to direct those who they cannot assist to the necessary and appropriate services through established referral mechanisms.

4.4. Language barriers

There is a large body of evidence from many settings that strongly suggests language barriers in healthcare settings contribute to health disparities (Saha and Fernandez, 2007) and that facilitating communication through interpretation services may be the most critical intervention to improve migrants' experiences with the healthcare system (National School of Public Health, 2010). While language barriers were not a significant factor for the majority of participants in our study (as a direct result of our selection criteria), several healthcare providers described an unmet need for translators in order to improve access for their facility's catchment population. Past research in Eastleigh demonstrated that language barriers were the primary reason that members of the Somali community gave for not using public services.

Evidence shows that diminishing language barriers 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 resulting in less need to seek services (Saha and Fernandez, 2007). With a growing number of second- and third-generation migrants who were born in Kenya and are eligible for employment at health facilities, the incorporation of translation services into public programming, particularly in migrant-populated neighborhoods may be a strategic step forward.

5. Limitations

The primary limitation of our 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.

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 cannot necessarily be generalized to all migrants in all locations within Nairobi.

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.

6. Conclusion

While the experiences of urban migrants' access to healthcare has been studied in European and North American countries, few studies have focused on migrants' access to healthcare in urban African contexts. Our results provide initial evidence that in several neighborhoods considered as spaces of vulnerability, migrants share many of the same barriers to accessing healthcare as Kenyans with regards to dimensions of availability, geographic accessibility and financial accessibility; however migrants may be additionally burdened by factors that relate to the acceptability dimension of services in Nairobi.

The results of our project, in combination with past research on access to healthcare for migrants in Nairobi, as well as lack of official comprehensive demographic data about the migrant population in Nairobi suggests a need for further research and action to allow for monitoring of migrant health issues and to measure improvement as relevant policies and programs are enacted. Both the government and organizations that target vulnerable populations in Nairobi must recognize the need for inclusive strategies to effectively manage the continuously growing population of urban migrants both in Eastleigh and beyond, and work toward realizing this population's right to health in a country that asserts a policy of equitable healthcare for all. Doing so may help to reduce health disparities that migrants experience, while simultaneously alleviating the 'spaces of vulnerability' effect and improving health outcomes for the Kenyan population at large.

Stakeholders in migrant health can 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 the government and other organizations ensure that in targeting 'persons of concern' they are not inadvertently failing to include certain individuals – for example irregular migrants. Allied organizations should be aware of one another's activities, and both establish and test referral systems. Migrant-sensitive services can be improved in part by eliminating language barriers and discrepancies in charges that restrict access for migrants. Additionally, cultural competence training of healthcare providers who work with diverse client populations and public awareness-raising of the health and human rights 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 (National School of Public Health, 2010). This may also help to alleviate any perceived threats of harassment for migrants traveling outside their own community to access healthcare services. Lastly, continued research and monitoring of migrant health that collects official population demographics (both nationally and by healthcare facilities), 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).

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