

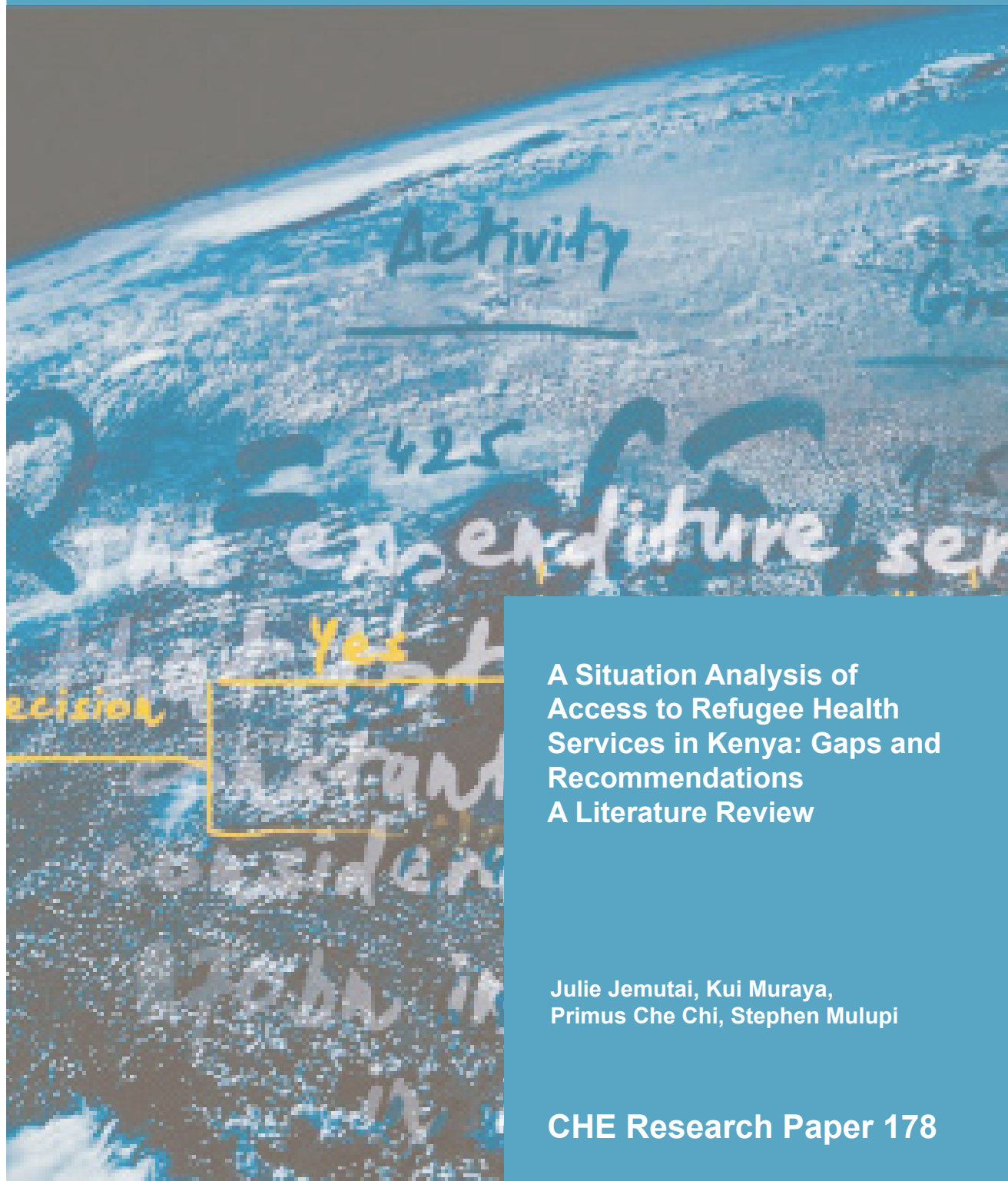


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**A Situation Analysis of
Access to Refugee Health
Services in Kenya: Gaps and
Recommendations
A Literature Review**

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CHE Research Paper 178

A situation analysis of access to refugee health services in Kenya: Gaps and recommendations - A literature review

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Acronyms and Abbreviations

ANC	-	Antenatal Clinic
CRRF	-	Comprehensive Refugee Response Framework
DRA	-	Department of Refugee Affairs
FGM	-	Female Genital Mutilation
GCR	-	Global Compact on Refugees
IASC	-	Inter-agency Standing Committee
IOM	-	International Organisation for Migration
KEPH	-	Kenya Essential Package for Health
MCH	-	Maternal and Child Health
mhGAP	-	Mental Health Gap Action Programme
MHPSS	-	Mental Health and Psychosocial Support
NHIF	-	National Health Insurance Fund
PTSD	-	Posttraumatic Stress Disorder
RCW	-	Refugee Care Workers
RSD	-	Refugee Status Determination
SGBV	-	Sexual and Gender-Based Violence
SRH	-	Sexual and Reproductive Health
UNHCR	-	United Nations High Commissioner for Refugees

1. Background

1.1 The refugee situation in Kenya

The Government of Kenya maintains an open-door asylum policy and two of the world's largest refugee camp complexes (Kakuma/Kalobeyei and Dadaab) are found in Kenya. The majority of refugees and asylum seekers in Kenya originate from Somalia (53.7%). Other major nationalities are South Sudanese (24.7%), Congolese (9%) and Ethiopians (5.8%). Persons of concern from other nationalities including Sudan, Rwanda, Eritrea, Burundi, Uganda and others make up 6.7% of the total population of 494,921, as at the end of June 2020. Table 1 below summarises refugees and asylum seekers in Kenya by country of origin [1].

Table 1: Refugee and asylum seekers in Kenya by country of origin, as at June 2020

Country of origin	Number of refugees and asylum seekers	Percentage of refugees and asylum seekers
Somalia	265,933	53.7
South Sudan	122,371	24.7
Democratic Republic of Congo (DRC)	44,636	9.0
Ethiopia	28,795	5.8
Burundi	16,047	3.2
Sudan	10,020	2.0
Uganda	2,582	0.5
Rwanda	1,876	0.4
Eritrea	1,845	0.4
Others	816	0.2
Total	494,921	100

Source: United Nations High Commissioner for Refugees (UNHCR)¹

The Dadaab refugee camp complex is located near the border with Somalia in Garissa County, and had a population of 217,516 registered refugees and asylum seekers, as at the end of June 2020. Dadaab refugee complex consists of three camps (Ifo, Dagahaley, Hagadera). The first camp was established in 1991, when refugees fleeing the civil war in Somalia started to cross the border into Kenya. A second large influx occurred in 2011 when some 130,000 refugees arrived, fleeing drought and famine in southern Somalia. There is a considerable difference between the old and new camps. A large part of the residents in the old camps have children and grandchildren born in the camps and the camps resemble naturally-grown towns that have developed into commercial hubs connecting north-eastern Kenya and southern Somalia. In contrast, most of the residents in the new camp, Ifo 2, came during the 2011 famine and are mainly pastoralists [2].

Kakuma refugee camp, on the other hand, is located near the border with South Sudan, Ethiopia and Uganda, on the outskirts of Kakuma town in Turkana County. Kakuma camp and Kalobeyei Integrated Settlement had a population of 196,645 registered refugees and asylum-seekers at the end of June 2020 [1]. The camp was established in 1992 following the arrival of the 'Lost Boys of Sudan' [3]. During that year, large groups of Ethiopian refugees also fled their country following the fall of the Ethiopian government. With an influx of new arrivals in 2014 (following conflict in South Sudan), Kakuma surpassed its capacity by over 58,000 individuals, leading to congestion in various sections. Following negotiations between the United Nations High Commissioner for Refugees (UNHCR), the National Government, the County Government of Turkana and the host community, land for a new settlement was identified in Kalobeyei, situated about 40 kilometres northwest of Kakuma [4]. In addition to decongesting Kakuma Camp, the Kalobeyei Integrated Settlement was established in recognition of the need for a different approach to refugee assistance, that promotes better integration between the host and refugee communities, and that also benefits the former.

The settlement is therefore intended to promote the self-reliance of refugees and host communities by providing them with better livelihood opportunities and enhanced service delivery.

Despite Kenya's policy of encampment, both registered and unregistered refugees and asylum seekers live within urban areas of Kenya, with their presence implicitly endorsed by the government. It is worth noting that the encampment policies are still largely in force despite a 2017 court of appeal decision deeming them unconstitutional. As of June 2020, the UNHCR's Urban refugee program catered for 80,760 registered asylum-seekers and refugees residing primarily in the capital city Nairobi, and other urban locations including Mombasa, Nakuru, Eldoret, Kitale, Meru-Maua, Isiolo and Bungoma [5]. Figure 1 shows the locations of the three major refugee camps in Kenya.

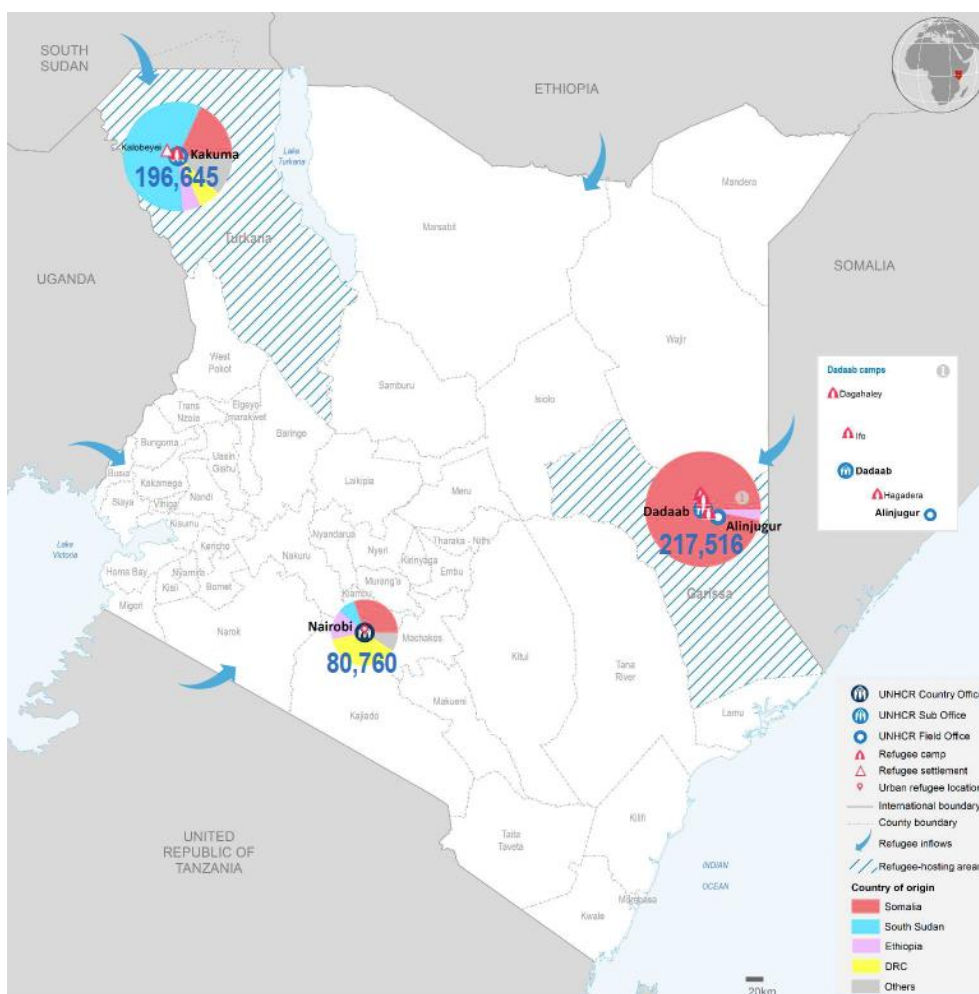


Figure 1: Kenya Registered Refugees and Asylum Seekers from UNHCR Statistics Report

Source: United Nations High Commissioner for Refugees (UNHCR)¹

1.2 Policy & political context

The evolving political and economic contexts, since the 1960s to date, have progressively shaped the refugee situation in Kenya. Three main issues cut across the timeline: the rise in refugee population, changes in individual liberties, and socio-economic opportunities. Kenya has enjoyed relative peace and stability, compared to her neighbours in Eastern and Central Africa. In the 1960s, the refugees came from only three countries (Ethiopia, Uganda and Somalia), and their population was estimated at only 5,000 [6]. These refugees could freely move and work anywhere in Kenya, including in the formal sector. Government was in charge of the refugee affairs [6].

From 1991, civil wars erupted in Somalia, Ethiopia, Sudan and the Great Lakes region resulting in a massive influx of refugees to Kenya. Consequently, the Kenyan government started Dadaab and Kakuma camps. Rising insecurity was linked by host populations, to refugees, further alienating them from the former [6]. During this same period, the UNHCR also assumed dominant roles of managing refugees affairs in Kenya [6,7]. The refugees also suffered the perverse effects of structural adjustment programs prescribed on poor nations by the World Bank, and added to discrimination as Kenyan citizens perceived them as competitors in the fast-shrinking opportunities in the job market.

Over time, the Kenyan Government, in partnership with the UNHCR and other United Nations (UN) agencies and international and local non-governmental organisations (NGOs), progressively developed policies and programs aimed at securing the health and welfare of the refugees [8]. In 2006, the Kenyan Parliament passed the Refugees Act (2006) [9], that provides for 'the recognition, protection and management of refugees'; and covers a broad range of areas including the process of administration, management and coordination, and rights and duties of refugees [9]. This law was enacted on May 15, 2007, and is grounded within the Convention and Protocol Relating to the Status of Refugees [10]. Despite the existence of this policy, its implementation has been 'patchy' and problematic, resulting in potential adverse consequences for refugees and asylum seekers.

The Ministry of Interior and Coordination of National Government in the Office of the President discharges government functions relating to refugees, initially through the Department of Refugee Affairs (DRA). However, in 2016, the DRA was disbanded and replaced with a less resourced but politically powerful Refugee Affairs Secretariat (RAS), that was granted the responsibility for management of refugee affairs [11]. The RAS is mandated to undertake the following: registration of asylum seekers and refugees in Kenya; managing refugee camps, reception and transit centres; coordination of humanitarian assistance programs to refugees and surrounding host communities; refugee status determination (RSD); and addressing refugee needs and referring them to relevant authorities, among others [12].

In September 2016, the UN unanimously adopted the New York Declaration for Refugees and Migrants that laid out a vision for a world in which refugees can thrive, and where there is shared global responsibility. The Declaration paved the way for the adoption of the Global Compact on Refugees (GCR) in 2018 that 'represents the political will and ambition of the international community as a whole for strengthened cooperation and solidarity with refugees and affected host countries' [13]. The GCR and its accompanying Comprehensive Refugee Response Framework (CRRF) has four key objectives: easing the pressures on host countries; enhancing refugee self-reliance; expanding access to third-country solutions; and supporting conditions in countries of origin for return in safety and dignity. Although Kenya did not attend the Leader's Summit in September 2016, it signed on the CRRF in October 2017 [11]. The RAS serves as the focal point for rolling out the CRRF in Kenya; the publication of the roadmap is still being awaited.

Refugee policies in Kenya have restrictive implications on the socio-economic entitlements of concerned populations, compared to, for example, neighbouring Uganda, with restrictions on the freedom of movement and right to work [9,14,15]. There are major funding gaps with UNHCR support for refugees at only 32% funded in Kenya [16]. With generally limited opportunities to integrate with the host populations, refugees use their social networks as support mechanisms and draw on alternative forms of governance. Although refugees have limited socio-economic opportunities, both skilled and unskilled persons work in the informal sector or are employed by aid organisations and paid incentives rather than full salaries [11].

1.2.1 Political unrest, closure of the refugee camps in Kenya

Further deterioration in security, particularly through terrorist activities prompted even more restrictive policies on refugees. In 2013, the Kenyan government ordered the encampment of all refugees including those living in urban areas such as Nairobi, Mombasa and Nakuru; with movement outside the designated camps requiring special documentation. This order disproportionately disadvantaged refugees, particularly those who were engaged in informal income-earning activities [7]. Furthermore, in October 2015, a conference was held in Brussels to seek support for the voluntary repatriation of Somali refugees and their reintegration in Somalia [17]. Between 8 December 2014 and 30 June 2015, 85,067 Somalis had been assisted by UNHCR and partners to voluntarily return to Somalia from Kenya. This exercise was however fraught with controversies, in part, because it was not entirely voluntary, as agreed within a tripartite agreement between Kenya, the Somali government and the UNHCR [18], and was in contravention of international law [7]. The repatriation exercise was subsequently stopped through a court ruling [7]. The government, however, made changes to the refugee law to limit the number of refugees entering the country, and a requirement for all refugees to be encamped.

In May 2016, the Kenyan government announced a decision to shut down the Dadaab refugee complex and repatriate all refugees, back to their countries of origin (which also resulted in the disbandment of the Department of Refugee Affairs, as previously mentioned), citing that the Somalia-based Al Shabaab militants were using it as a base to plan terrorist attacks in Kenya [19]. However, this decision was blocked by the High Court in 2017, citing the move as unconstitutional and in violation of Kenya's international obligations. In February 2019, the government renewed its decision to close the camp and requested the UNHCR to expedite relocation of the refugees and asylum-seekers residing in the camp. To date, however, the camps are still operational albeit ongoing voluntary repatriations [18].

1.3 Refugee access to healthcare in Kenya

Refugees in Kenya generally experience challenges in access to health care, whether they are in the rural camp complexes like Kakuma/Kalobeyi, or Dadaab or urban areas like Nairobi. Nonetheless, those in the camps are slightly better off, as these settings are generally designed to provide humanitarian assistance to the refugees including health, education and livelihood opportunities, among others. Such elaborate refugee dedicated systems do not exist in urban settings and refugees are often left on their own to fend for themselves and their families [20]. Although the 2010 Constitution of Kenya [21] stipulates the right to health for every person in Kenya, refugees continue to experience unique barriers in accessing healthcare. A 2014 qualitative study [22] among urban refugees in Nairobi found that while some barriers to accessing healthcare are common to both refugees and local Kenyans living within the same areas, other barriers were unique to the refugee population [22]. The common barriers included long waiting times, acute shortage of drugs, and lack of transportation due to poor road networks within the informal settlements where they live. On the other hand, the reported unique barriers were discrepancies in healthcare cost between refugees and local Kenyan clients, requirements for documentation before service, threat of harassment, and language barriers.

Recognising the unique plights faced by some urban refugees, in 2005, a local NGO known as Refugee Point, set up a small medical clinic in Nairobi to care for a small group of about 50 HIV positive refugees and their families, and later expanded their clients to include refugees who were not HIV positive but had some major vulnerability [23]. This included homeless refugees, unaccompanied children, child-headed households, disabled refugees or those with severe physical or mental health conditions, and victims of physical and sexual abuse with ongoing symptoms, among others. As demand for their services grew, they began partnering with other city clinics in Nairobi to expand health access to refugees. Since 2008, the NGO has been partnering with Nairobi's

city council and the Kenyan Ministry of Health to reach refugees in Nairobi with public health information and vaccination campaigns [24]. They have equally replicated the community health worker model within some refugee communities in Nairobi, by hiring a cadre of refugee community navigators to communicate about health and other critical information to their communities in Nairobi, by going door to door in their assigned blocks.

A more recent 2019 study found that major barriers to accessing health care persist among urban refugees in Nairobi. These include language, location, cost, provider attitude, discrimination and lack of National Health Insurance Fund (NHIF) cards/health insurance, with cost being the most important barrier [25]. The authors noted that regardless of their registration status, most urban refugees in Nairobi receive little support from humanitarian organisations compared to those that are in camps – a situation associated with the fact that such urban refugees are dispersed across different areas, while camped refugees are located within a specific area, where humanitarian organisations implement their projects. Additionally, the prevailing refugee encampment policy in Kenya that prohibits refugees from leaving the camps, has resulted in a situation where many refugees in urban areas are not registered with the relevant refugee agency [25], further exacerbating the challenges to accessing healthcare for urban refugees. They also noted that refugees sought healthcare from a wide range of providers, including government, religious and private health facilities, pharmacies, mobile health clinics, community health workers, shops, and traditional healers/herbalists; with the government health facilities being the predominant source of healthcare.

With regards to governance of refugee health issues, the UNHCR and RAS play an important role in administrating the refugee camps in partnership with the various county governments. Healthcare in the refugee camp complexes is overseen by UNHCR and largely provided free-of-charge through a range of NGO partners. For example, the International Rescue Committee runs a general hospital in the Kakuma camp, a hospital in Hagadera in the Dadaab complex, and a number of clinics/health posts; Médecins Sans Frontières (MSF) runs two health posts in Dadaab; and the Kenyan Red cross runs a 100-bed referral hospital and two health posts in Dadaab. Although dedicated health facilities for refugees are available within the refugee camps in Dadaab, Kakuma and Kalobeyei, they appear to be inadequate when compared with the population they are intended to serve. For example, a 2017 survey among recently arrived South Sudanese refugees and host populations in the refugee settlements of Kakuma and Kalobeyei found that refugees had a limited number of clinics available to them, and often waited in long queues to receive usually inadequate care [26].

UNHCR also facilitates for (registered) urban refugees to access health care in some government health facilities, either free of charge or at subsidised rates. On the other hand, unregistered refugees face significant challenges when accessing government health facilities [25]. Considering this unique challenge of unregistered urban refugees who may want to remain invisible, efforts need to be made by relevant stakeholders to identify and provide this vulnerable group with adequate and appropriate health services [20]. An important gap that requires urgent attention will be initiatives to identify and provide basic health services to unregistered urban refugees.

In the section that follows, we delve deeper into three illustrative ‘case studies’ to further understand healthcare accessibility issues within refugee populations in Kenya: Maternal and child health (MCH), sexual and reproductive health (SRH), and mental health. These three illustrative case studies were purposively selected to reflect a ‘disproportionate need’ within the refugee communities in Kenya. Statistics from UNHCR show that, as at the end of June 2020, 79% of all registered refugees and asylum seekers in Kenya were women and children [1]. This suggests a need to pay particular attention to services targeted to these populations; and which informed our choice of case studies around MCH and SRH. Furthermore, due to their general living conditions, war-

related trauma and migration history, and the socio-political environment in Kenya, refugees - especially those in urban areas - have been shown to be more prone to suffering mental health problems compared to the local population [27,28]; which informed our choice for the third illustrative case study (mental health). Overall, increased and better understanding of these refugee health needs and potential barriers to accessing adequate health care is an important priority for improving refugee health and wellbeing. It is worth noting that in compiling this report - and specifically the illustrative case studies - the authors faced difficulties in identifying specific (or recent) literature and reports related to access to healthcare services for refugees in the Kenyan context. This dearth in literature is very concerning given that Kenya has been hosting refugees for decades now, and we strongly recommend the need for further comprehensive work in this area.

1.4 Methodology

This study is a University of York, UK commissioned research work as part of the REfugees in Africa ClusTer (REACT) Project that aims to support national capacity-strengthening and research in gender responsive resource allocation, health care organisation and policy decision-making for more efficient and equitable responses to refugee and host communities health needs in East, Central and Southern Africa. This specific report seeks to summarise key aspects of health systems and policy design affecting access to health services for refugee populations in Kenya. It primarily draws on an in-depth review of published and grey literature around access to healthcare for refugees in Kenya.

1.4.1 Outline of report

This report has four main sections. Section 1 introduces the refugee situation in Kenya, policy and political context, and refugees' access to healthcare. In section 2, three illustrative case studies on refugees' access to healthcare are presented, with focus on maternal and child health, sexual and reproductive health, and mental health. Refugees' access to healthcare within the broader health system is discussed in section 3. The report concludes with programme and policy recommendations in section 4.

2. Access to healthcare among refugees

2.1 Maternal and Child Health (MCH)

2.1.1 *Current situation, gaps and challenges in accessing MCH services*

Although the UNHCR and its partners work to provide health and medical care to refugee populations globally including in Kenya; the rapid review undertaken for this work suggests a general dearth in literature and public reporting for access to maternal and child health services – with literature on the latter being even more scanty. This is despite one of the goals of the 2014-2018 UNHCR’s Global Strategy for Public Health being to improve childhood survival including through measurement and evaluation of implemented programs [29]. The available identified literature on maternal healthcare focused primarily on *access* to antenatal care (ANC) services with less attention given to other services, such as labour and delivery services and postnatal care (or even *quality* of care including of the ANC services). Childbirth and the immediate postpartum period have been shown to be critical in relation to maternal mortality, and more attention needs to be given to this area of work to explore access, utilisation and quality of related services [30, 31]. Only one comprehensive report was identified, published in 2011 by the International Organisation for Migration (IOM) [32], following a pilot study on access to maternal and early childhood healthcare for urban migrants in the Eastleigh area of Nairobi. Similar comprehensive reports and/or published articles could not be identified for either refugee camp settings in Kenya or more recent studies.

In Kenya, studies reporting on maternal care services seem to have focused on the Somali community, both in the Dadaab refugee camp complex and the urban area of Eastleigh Nairobi; compared to Kakuma camp/Kalobeyi settlement and other urban areas that host refugees. From these studies, specifically in relation to safe motherhood in refugee contexts, three main delays have been associated with maternal mortality. These are delays in seeking care, reaching care and receiving care [33]. For example, a UNHCR field brief on improving maternal care in the Dadaab refugee camps, suggests that some of the key issues in accessing care are due to: the camps being located in insecure areas and unavailability of public transport to enable refugees to reach health services, particularly at night; health agencies vehicles having been previously attacked and therefore not operating at night; and cultural factors which mean that many Somali women opt to deliver at home and are reluctant to consent to an emergency caesarean section even when critically indicated [34]. It is worth noting, however, that a study of maternal mortality in refugee settings in ten countries, including Kenya, undertaken between 2008-2010, suggested that in terms of contributing factors - for all countries - delays in seeking and receiving care were more prevalent than delays in actually reaching care [30]. In Kenya specifically (which had the highest number of reported maternal deaths of all ten countries), they found that delays in seeking or accepting care and provider failure to recognise the severity of the woman’s condition, were the most prevalent avoidable contributing factors [30].

A more recent mixed methods study in Somali communities in the Dadaab refugee camps concurs with the role of social and cultural factors in accessing/not accessing care [31]. They found that the strong desire for large families and the primary social role of the woman as child bearer impacted maternal and neonatal health in the camps, through preferences for early marriage, low demand for contraception, and avoidance of caesarean sections. Participants described how a strong fear of death, disability, and reduced fertility from caesarean sections results in avoidance of the surgery, late presentation to the health facility when in labour, and difficulty gaining timely informed consent. Mistrust of health service providers also played a role in this dynamic [31].

Nonetheless, a 2010 survey undertaken with urban refugee populations in the Eastleigh area of Nairobi (predominantly Somali community), and the subsequent 2011 analysis of the same population by the IOM, showed high use of ANC services with nearly 90% of pregnant women

attending at least one ANC visit [32,35]. The analysis suggested similar high – although not full - coverage of ANC services (83%) in refugee camps in Kenya as of 2010 [30]. It is, however, important to note that in both the camps and within the urban refugee population, most of the women still did not meet the requirement of four ANC visits [30, 32]. In the urban refugee population of Eastleigh, a lack of knowledge of the importance of ANC was the most commonly cited reason for inadequate access to ANC services despite recommendations. Proximity of health facilities to the home and affordability were cited as facilitators to accessing ANC services [32].

As earlier indicated, literature/reports on access to newborn and child health care services were even more limited. Nonetheless, the comprehensive report by IOM indicated that in the urban refugee population of Eastleigh Nairobi, 95% of children had been vaccinated with 65% fully immunised by one year of age. There was, however, much lower access to health facilities to seek care for sick children aged under five years. The reasons/barriers for not seeking treatment for ill children included: the child getting well on their own; carer did not think she needed to seek care for the child (perceived severity of illness); not knowing where to go or not having someone to accompany them to the health facility; health worker attitudes; and affordability of care [32].

Furthermore, the study with Somali communities in Dadaab refugee camp complex indicated that while mothers agreed on the importance of having babies checked at routine postnatal care appointments, they were often discouraged by the long queues at health facilities as well as the inconvenience of leaving the home during the early postnatal period [31]. Mothers in this study stated their first choice for care if their newborn was sick was the health post. If the baby did not get better, they would then try traditional herbs or, if they could afford it, go to private pharmacies. Reasons given for choosing the health post included free service, good quality doctors, and safe and reliable care. However, mothers highlighted that a key barrier to accessing care with a sick neonate is the lack of transport within the camps as ambulance services are restricted to women in labour [31]. Other cultural and religious beliefs (such as the use of 'Quran therapy' i.e. reading the Quran when the child is sick and perceived type of illness), also played a role in whether sick neonates were taken to a health facility [31].

2.1.2 Existing MCH interventions

Specifically, with regards to maternal care, in 2007 the UNHCR developed and introduced in all of its refugee camp programs (including Kenya), the Maternal Death Review Report [36]. This approach utilises multi-disciplinary investigative teams (comprising health personnel, community leaders, UNHCR staff and the host country's Ministry of Health) to collect information on the demographic characteristics, pregnancies and deaths of women who die of pregnancy-related causes. In addition to asking for quantitative data, the report form prompts investigators to obtain contextual information from family and key community members such as community leaders and traditional birth attendants, on the circumstances surrounding the maternal death. This helps to identify any missed opportunities for care which may result in maternal death. Furthermore, the report from such maternal death audits is then shared with the UNHCR Regional Office for review and to inform intervention strategies for both the host country and countries with similar refugee populations. According to Hynes and colleagues (2012), *'[these] targeted efforts in refugee camps to ensure surveillance of pregnancies by health care staff and provide transportation to maternal health services may have helped to minimise the prevalence of delays [in seeking care]'* ([30], pg. 211). It was unclear whether these maternal death reviews are still ongoing as no recent literature/reports on the same could be identified.

The proximity of NGO health clinics to refugee camps has also been shown to lessen the transportation time, and potentially promotes better access to maternal care and a reduction in delays to both seeking and reaching care [33]. Additional efforts to improve maternal health

outcomes were implemented in early 2009 by UNHCR and partners, and included improvements in facilities and transportation, addition of health staff, and local sensitisation and awareness campaigns [33]. In Dadaab refugee camp complex, for example, the UNHCR and its partners introduced '*Mama Taxis*' - community-run taxis that provide emergency transportation to women in the evenings and at night, when public transportation is unavailable. *Mama Taxis* have helped to reduce delays in seeking and reaching care, as women who use them seek out health services more often, even at night [33]. It is however worth noting that in the study of maternal and newborn health in Dadaab refugee camps, they found that delay in the arrival of the *Mama Taxi* was cited as the most common reason for women delivering outside of the health facility [31] highlighting the need to pay attention to the implementation of interventions.

2.2 Sexual and Reproductive Health (SRH)

2.2.1 Current situation, gaps and challenges accessing SRH services

Access to sexual and reproductive health care services within refugee settings in Kenya faces many challenges. A systematic review of 15 studies that explored evidence on sexual and reproductive health knowledge, experiences and access to services among refugee, migrant and displaced girls and young women (10-24 years) was conducted in nine African countries, including Kenya [37]. This review established that the young girls and women had limited knowledge on the full range of contraceptive methods and comparatively lower knowledge of modern contraceptives than adults, as well as low awareness on sexuality, abortion and pregnancy. This situation affected the demand for SRH services. Furthermore, there was low access to contraceptives associated with costs, distance to health facilities, and stigma surrounding use of contraceptives by adolescents. Other barriers included poor quality of services including lack of facilities for testing sexually transmitted infections, lack of acceptable and affordable contraceptives, and stockouts [37].

Another study was conducted on a more vulnerable group of refugees, the disabled, in Kenya, Uganda and Nepal [38]. Key access challenges reported in this study included: low awareness of sexually transmitted infections particularly among men and boys; misperceptions around contraceptive use; disrespect by healthcare providers, including an expectation that they should not be sexually active; long waiting times at health facilities; transport barriers and disability-unfriendly services such as a lack of sign language interpreters.

In another survey to assess adolescent SRH services in humanitarian settings, attitudes of community members towards pregnancy among the disabled varied depending on marital status, with unmarried women discriminated against, as the pregnancy was linked to promiscuity or rape. Consequently, such pregnant women would be exposed to violence. These attitudes are also associated to observed trends of sexual violence particularly amongst adolescent girls with intellectual disabilities in refugee settings. Additionally, unmarried women with intellectual disabilities were observed to have restricted autonomy over SRH rights. For example, some parents may force them to use contraceptive methods to avoid pregnancy as they were deemed as 'unfit' to raise a child; their movements were restricted, or they were subjected to harmful practices such as female genital mutilation [38]. The authors noted that workers in humanitarian settings receive little guidance on SRH services for refugees [38].

In particular, sexual and gender-based violence (SGBV) is a huge problem in refugee settings. SGBV includes: acts of physical, emotional and sexual violence; harmful traditional practices such as female genital mutilation (FGM); forced and early marriage; sexual exploitation and abuse [39]. In Dadaab, at least 60% of female SGBV survivors reported a lifetime experience of non-partner violence (NPV) while 66.7% reported intimate partner violence (IPV) in their lifetime. In the preceding 12 months of the survey conducted in Dadaab, 38.8% survivors of SGBV had experienced

NPV, while 51% experienced IPV [40]. SGBV exposes survivors to multiple health problems including sexually transmitted infections and physical and psychosocial trauma, even long after the violations.

As alluded to above, women and girls are disproportionately more affected by SGBV. Even then, among women and girls, particular groups are more vulnerable and at higher risk to SGBV than others. These include the disabled, women from smaller clans, single or unmarried women aged 35 or less, and girls in households 'without a traditional male provider/protector'; underscoring gendered vulnerabilities in patriarchal cultural contexts, where union in marriage or with intimate male partners are perceived to confer protection on women. Additionally, newly-arrived female refugees are more vulnerable to SGBV because they have fewer social networks and may be assigned less secure shelters [40,41]. Ageing and insecure tents have also been cited as exposing an estimated 30% of the refugee population in Dadaab and Kakuma to SGBV [8]. SGBV also happens in public spaces, within the camps, for example water points and footpaths. In Dadaab specifically, SGBV against women is used as a weapon of war during interclan fights to humiliate their husbands and male relatives [42]. Additionally, although men are the primary perpetrators of SGBV in refugee settings, they are also victims. However, such incidents may not be reported due to related stigma, masking the magnitude of the problem as it affects men [43].

Despite the introduction of SGBV centres in refugee camps in Kenya, reporting of cases and uptake of services remains sub-optimal (albeit increased). Survivors of SGBV may not report the incidents for fear of reprisals from perpetrators and being shamed and stigmatised by family and the community for 'exposing family secrets'. Furthermore, informal community mechanisms for recourse, 'Maslaha' are deemed as not supportive of the survivors [41]. Indeed, survivors may be blamed for 'not respecting husbands', and those raped may be accused of having 'loose morals' [40]. Additionally, studies suggest that some survivors experienced challenges in reporting SGBV due to unethical practices by camp personnel. For example, guards at the UNHCR office in Dadaab camp reportedly demanded bribes from survivors before they allowed them access to services [40]. The processes within the UNHCR are also perceived to be tedious and time consuming, thereby discouraging referral to appropriate services [40, 42].

Furthermore, refugee care workers (RCWs), who are lay workers drawn from the refugee community to support the SGBV response, often face opposition from perpetrators of violence and other community members. In some instances, such opposition assumed 'ideological assaults' that overall aimed to undermine RCW legitimacy. For instance, claims that RCWs championed foreign agenda that overall sought to destroy traditional cultural institutions and religious practices [42]. Consequently, some RCWs were threatened and exposed to physical violence and felt constrained to support SGBV care. Sometimes, RCWs own personal beliefs and support for cultural practices e.g. FGM, early marriage and wife-beating, also went contrary to their expected roles [42]. There were also perceptions that RCWs show bias associated to clan identities, as well as some survivors not being receptive to RCWs from a different clan. It was also reported that some RCWs may breach survivor confidentiality and may not interpret correctly to the professional staff; consequently, discouraging survivors from utilising their services [40].

Challenges reported in literature related to supply of professional care include inadequate capacities of healthcare workers to identify and provide appropriate care for survivors of SGBV [39]; and inadequate spaces in healthcare facilities to provide confidential screening, with the screening processes sometimes happening in shared consultation rooms. Furthermore, the additional screening roles increased the workload on already strained staff. Providers' professional perspectives also sometimes conflicted with survivors' own constructions of SGBV. For instance, some women did not perceive certain incidences e.g. marital rape and forced pregnancy as SGBV, because of religious and cultural leanings [39]. Operational challenges also hindered immediate

access to subsequent needed psychosocial support, in turn associated with postponement of accessing referral services, sometimes due to competing priorities, such as household chores [40, 42].

2.2.2 Existing SGBV interventions

The Kenya Comprehensive Refugee Programme outlines the priority areas in strengthening the SGBV response [44]. In 2015, an additional 1 million USD was added to the 2015 budget for Dadaab, Kakuma and Nairobi Urban refugee program. Priority areas include SGBV case management and referral, enhanced judicial processes, training for critical stakeholders such as partners, community workers and security personnel; enhanced advocacy and engagement with police officers to improve confidential processes for reporting of SGBV. Another priority is the use of Gender-Based Violence Information Management System to support decision-making relating to SGBV [43, 45].

As earlier alluded to, one response to the SGBV problem in refugee settings has been establishment of 'GBV service centres' [40]. These facilities are managed by professional refugee agency staff. Key services include provision of healthcare, psychosocial support and linkage to other necessary interventions including law enforcement, judicial systems and facilitating additional protection, for example through safe houses. Refugee care workers (described earlier) also receive basic training on identification of SGBV cases; linkage to appropriate service centres; and continued support and awareness creation on SGBV in the community, to accelerate behaviour change. The RCW intervention has been associated with an observed increase in reported cases of SGBV, partly because - most times - survivors trust them [41, 42]. The RCW model is also perceived to reduce workload overall of professional staff on GBV work (barriers and facilitators). Generally, refugee agency workers report that SGBV is perceived to be on a declining trend compared to previous years [40]. This is associated with improved security in the camps, enhanced awareness of the community on SGBV, declining influx of new refugees and reduced inter-clan conflicts [42].

2.3 Mental health

2.3.1 Current situation, gaps and challenges accessing mental health services

There are currently limited research studies exploring the epidemiological profiles and clinical research outcomes of mental health related problems in refugee settings in sub-Saharan Africa [46-48]. Nonetheless, available studies show that refugees face a lot of atrocities during and after displacement, leading to mental health problems triggered by the experience of violence, killings, separation, torture, SGBV and child soldiering [29]. Compounded with difficult living conditions, socio-cultural barriers and uncertain employment situations, refugees are at a higher risk of depression, anxiety and post-traumatic stress disorder (PTSD) [49-52]. Children in refugee camps are also at risk of developing emotional and behavioural problems. Due to mass displacement, traditional support structures such as those from extended family members and community networks are broken, leading to challenges with coping mechanisms and resilience [53]. Generally, there is the sense of feeling hopeless, idleness and isolation amongst refugees. Those with physical disabilities and mental illness face more stigma and discrimination, for example, the amputees have in some cases been ridiculed or stoned for having a disability [54].

Facing numerous constraints and difficult living conditions in the refugee camps, there is the surge and influx of refugees to urban areas [28]. For urban refugees, there is increased risk of living in crowded areas, fear of deportation and increased visibility, making accessibility to services more difficult [27, 55]. Refugees living in urban areas face comparable mental health problems with those in camps and in rural areas [27, 56]. Amongst the Somali women in Eastleigh, Nairobi, there have been reports of high level of stress and gynaecological related problems that contribute to mental illness such as complications as result of FGM [57].

A systematic review of 181 surveys of refugee and conflict-affected populations, in 40 countries, found a 30% prevalence of PTSD and depression in these populations [46]. The significant predictors of PTSD and depression were exposure to torture and total number of trauma events respectively. Prevalence of PTSD in non-refugee populations is much lower at 1.1% [58], indicating the critical need for mental health support for refugee populations. More studies have been conducted showing much lower prevalence at 15% which still exceeds the non-refugee prevalence estimate [51]. Qualitative studies conducted in Kakuma and amongst Somali refugees in Nairobi show both individual functional challenges (e.g. lack of livelihood, financial resources, education, substance abuse and domestic violence) and structural challenges (e.g. violence, insecurity, lack of community support, opportunities and legal options, cultural issues, and social discrimination) for refugees [28, 59]. Promotion and accessibility of mental health and psychosocial support (MHPSS) services is therefore critical in the refugee population.

In Kenya specifically, restrictive policies such as those indicated in The Refugee Act (2006) [9] which curtail movement out of the camps and right to work for refugee populations in Kenya can further exacerbate mental health stressors in these vulnerable populations. Although geared towards national safety, these policies introduce discrimination and injustices that can increase mental health vulnerabilities for refugee populations; highlighting a need for these policies to be re-evaluated using a health and wellbeing lens. Despite the growing need of MHPSS services, and conditions imposed on refugees including restrictive access to services, mental health professionals face a lot of ethical dilemmas when working in such environments with restrictive conditions [51].

Barriers to access of health services highlighted in literature includes language and communication barriers with concerns on the use of informal (such as family members and friends) interpreters (commonly used in health facilities) in relaying the accurate information to health workers and also breach of confidentiality [27]. For instance, some of the Somali words may not be translated into English or Swahili making difficult for health care professionals to understand the condition. Lack of culturally sensitive mental health services is a key barrier for refugee populations to access mental health services within the camps.

The World Health Organisation (WHO) recommends that governments integrate mental health services into primary care to enhance access, increase cost-effectiveness and affordability and improve outcomes particularly linked to secondary care and community [60]. In the general population, a small minority access mental health services and with increased stigma and unfavourable policy restrictions; refugee population access to mental health services is even much lower. Kenya has faced several challenges in integrating mental health in primary care. The main barriers are: limited financial resources and human resource capacity, overloaded primary health care services, and lack of training and continuous professional development [61, 62]. The Kenya Mental Health Policy 2015-2030 [63] was developed to reform mental health needs in the country with one of the key objectives being to integrate mental health services within the Kenya Essential Package for Health (KEPH). Despite these efforts by the government to reform the mental health environment in Kenya more broadly, the policy fails to acknowledge the need for specific support for vulnerable groups such as refugee populations [63].

2.3.2 Existing mental health interventions

The main treatment interventions for common mental health disorders include counselling and psychotherapies [51]. In the past two decades, psychotherapeutic packages have been developed and implemented in refugee contexts but mostly based on evidence from the Western context [51, 64]. The existing gap in interventions applicable to local contexts led to development of programs that allowed training of front-line workers and enabled task-shifting to lay or community health workers to allow uptake and dissemination MHPSS services.

The Inter-agency Standing Committee (IASC) and UNHCR [53, 65] provide guidelines to support MHPSS services and support in emergency settings in low and middle-income countries (LMICs) that entails emergency preparedness, minimum responses to be implemented as soon as possible in an emergency setting, and comprehensive responses once minimum responses have been implemented. The guidelines illustrate the layered interventions system by which MHPSS is provided and implemented in meeting the needs of different groups (Figure 2).

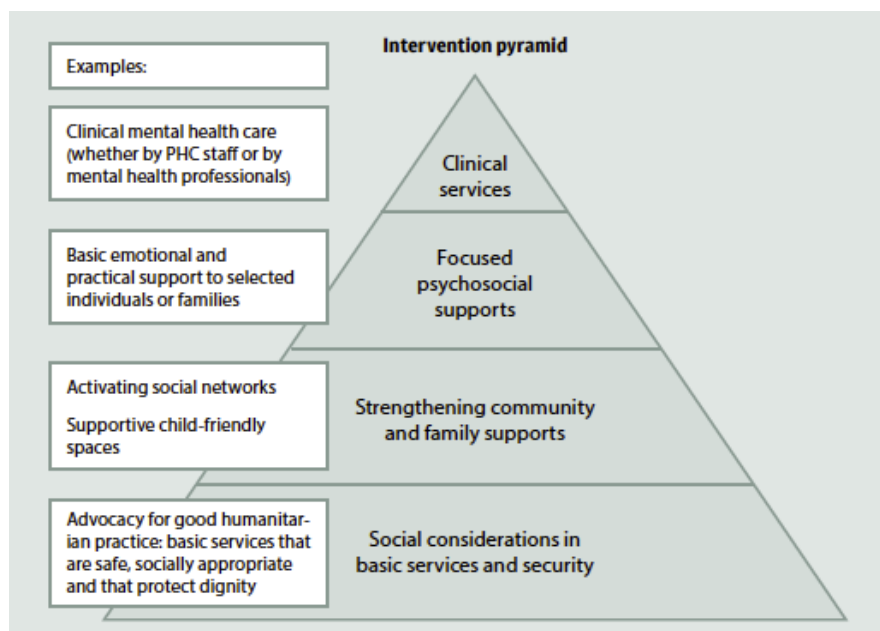


Figure 2: IACS intervention pyramid for MHPSS in emergencies adapted by UNHCR

Basic services and security should be established to ensure security, adequate governance and services that address basic needs. These interventions may include advocating for the needs of refugees by key actors, documenting their impact on mental health, and ensuring key actors in humanitarian response, including governments, deliver these basic needs. The basic services should be layered in a safe environment with clear communication strategies that strengthens community and family support structures. The more focused, non-specialised support may include individual, group or family interventions by trained and supervised workers, and in most cases, basic mental health care by primary health care workers. Specialised services that would mostly include clinical services are provided to those that require additional support and may have extreme difficulties with daily function. The interventions may include support from specialised health workers and referral care [53,65].

MHPSS interventions that currently exist in Kenyan refugee settings include psychosocial support, psychotherapy and clinical services, community sensitisation on MHPSS issues, local advocacy strategies and local mental health capacity building [27, 51, 54, 66]. The specific components/activities of each of these interventions and their targeted groups within the Kenyan Refugee context is detailed in Table 2.

Table 2: Mental health and psychosocial support intervention in Kenyan refugee camps

MHPSS interventions	Activities	Targeted person(s)
Psychosocial support	<ul style="list-style-type: none"> ● Counselling of individual and groups [54] ● Training and supervision for local capacity [52, 66, 67] ● Home follow-up visits [68] ● Raising awareness on MHPSS issues [27, 66] ● Local advocacy for community support [66, 67] 	<ul style="list-style-type: none"> ● Refugees particularly the most vulnerable i.e. women, children, disabled, mental health illness
Clinical mental health services	<ul style="list-style-type: none"> ● Referrals for medical care [49, 51] ● Cognitive behavioural therapy ● Psychosocial and mental disorders assessment 	<ul style="list-style-type: none"> ● Refugees with mental health illness
Community sensitisation	<ul style="list-style-type: none"> ● Community outreach support ● Community awareness ● Community education 	<ul style="list-style-type: none"> ● Refugees ● Community health workers
Local advocacy strategies	<ul style="list-style-type: none"> ● Coordination groups (e.g. Dadaab Mental health coordination group) and network to share experience and expertise [54] 	<ul style="list-style-type: none"> ● Non-governmental organisations ● Government
Capacity building	<ul style="list-style-type: none"> ● WHO mhGAP* Humanitarian Intervention Guide training [67, 69] ● Local training of refugees to provide MHPSS [53, 54, 66, 67] ● Continued training and supervision [67] 	<ul style="list-style-type: none"> ● Health care providers and workers ● Refugees ● Teachers ● Religious community leaders

*mhGAP – WHO Mental Health Gap Action Programme

In summary, access to healthcare for services such as mental health support, SRH and MCH by the refugee population is critical in ensuring a fair and equitable system, and this can be achieved by making deliberate decisions to have an integrated healthcare system for the refugee and host populations.

3. Refugees' access to healthcare in the broader health system

Given the unique challenges experienced by refugee populations in accessing health care services, outlined in section 2 above, integrating refugee health within the broader health system could be beneficial and promote more rational use of limited available resources. An integrated refugees and host population health system can be defined as the provision of health services to both refugees and host populations alike, within the structure of the host country's health system, in a way that refugees and host population can access the same healthcare resources from the same providers [70]. It contrasts with the parallel refugee-centred health system model - such as that observed in Kenya - that is separate from the host country health system, with health facilities and services largely managed and provided by humanitarian organisations. An integrated health system should be built on principles such as equitable access to health services, equality and non-discrimination among others, as articulated in the WHO's framework for 'promoting the health of refugees and migrants' [71]. These principles are aligned with the 2030 Agenda for Sustainable Development of leaving no one behind, and the health-related commitments in the CRRF.

Within an integrated health system, limited resources (financial, technical etc.) are better maximised for quality health care provision. It can also reduce the risk of tensions around perceived inequality in access and quality of health care between refugees and host populations, and improve integration and cohesion between these groups. Additionally, channelling international resources through the host country's health system could, in the long term, strengthen the system and build community resilience

As mentioned earlier, the CRRF seeks to achieve the following four objectives: ease pressure on host countries, enhance refugee self-reliance, expand access to third-country solutions, and support conditions in countries of origin for return in safety and dignity. It promotes a 'whole of society' approach to refugee responses [72]. Therefore, the CRRF among other issues seeks to better support refugee-hosting countries and ensure that refugees are integrated within local host communities from the start with the goal of improving the provision of basic services such as healthcare and livelihood opportunities [73]. There is, however, a general perception among stakeholders that the current encampment policy in Kenya remains a substantial barrier for effective refugee integration and, by extension, effective integration of the refugee health system with the local host population health system. As detailed in section 1, in a bid to foster integration of refugees within host communities, a dedicated settlement (Kalobeyei Integrated Settlement) was set up in the environs of Kakuma camp hosting both refugees and the local population. The settlement is 'designed to enable refugees and the host community to live side-by-side, sharing markets, schools, and hospitals' [26]. UNHCR, in consultation with the government, designed the Kalobeyei Integrated Social and Economic Development Program (KISEDIP) - a 14-year multi-agency collaborative plan with the goal of developing the local economy and service delivery systems [74]. One of the goals of KISEDIP is improving the availability and quality of service delivery for refugees and the host community [75].

An important component of the self-reliance of refugees and better integration between refugees and local host populations has been initiatives to improve the integration of refugee and host country health systems. In 2014, the UNHCR launched a Global Strategy for Public Health for 2014-2018 [29]. The sixth objective of that strategy was to 'ensure integration into national services and explore health financing mechanisms', with a monitoring indicator of 'Do refugees have access to national health services equally to the national population?' Based on this strategy, the UNHCR proposed preferentially financing national health service delivery programs that are available for refugees, rather than setting up parallel services. Integration of refugees and host country health systems should, therefore, create a health system where both refugees and host populations can

access affordable and high-quality services without restrictions. It is, however, important to highlight that due to Kenya's refugee camp complex structure, most refugees are predominantly located in camps, where the local populations are in the minority, as in the case with Dadaab and Kakuma camps. Even in the Kalobeyi Integrated Settlement, refugees (60,000) still vastly outnumber the locals (20,000). The only exception to this being in the urban areas where refugee populations are a minority [5].

In Kenya, it does not appear major stakeholders have deliberately made efforts in the past to integrate refugees and host population health systems. However, an EU Emergency Trust Fund for Africa 2018 adopted and funded project in the context of the CRRF, appears to signal a more deliberate approach to incorporate refugee and host population health system integration within the broader CRRF goal of ensuring refugee self-reliance [76]. The project titled 'Enhancing self-reliance for refugees and host communities in Kenya' aims to enhance the self-reliance of refugees and host communities in Kenya [76]. Specifically, it seeks to: enhance the Government of Kenya's overall asylum management and support government-led CRRF roll-out at both national and county levels; contribute to the implementation of the KISED P for refugees and host communities in Turkana County; and improve economic self-reliance of refugees and host communities in Garissa County.

The project aligns with the Government of Kenya's Big Four Agenda (of affordable housing, food security, manufacturing, and universal health coverage), that includes accessible and affordable quality healthcare to all, by ensuring that every person in Kenya is covered under the NHIF medical coverage. Under the project, there are plans *'to pilot NHIF in 2020 in Kakuma and Kalobeyi in order to move away from the humanitarian model where UNHCR provides basic and tertiary health care through partners'* (p. 4). After assessing current health facilities in the camps and accrediting them into the NHIF, both refugees and the surrounding host community will be allowed to enrol into the scheme, with the goal of providing a more sustainable model of health care financing.

Some major relevant outcomes of the project include:

- Improving access to medical services for refugees and host communities in Turkana West (Kalobeyi and Kakuma refugee camps) by upgrading of health facilities in the camps to NHIF standards, followed by a roll-out of the NHIF programme. This will involve training of county officials/health personnel and NGO staff on NHIF.
- Improving access to inclusive health services for refugees and host communities in and around Dadaab by constructing new health facilities, provision of integrated health services, and training of medical personnel and a roll-out of the NHIF (including training of relevant stakeholders).

There are already some early positive signs at the Kalobeyi camps. The Kalobeyi 'Super' Health Centre that was completed and operationalised in 2017 under the KISED P plan is registered under the Turkana County government, and about 10 percent of all deliveries in the maternity have been from host community women [77]. By the completion of the project, the refugees and local population health systems should be better integrated across the various refugee camps complexes in Kenya. It is expected that over time the management and running of these health facilities will be transferred to the Government of Kenya, although some commentators have raised concerns around the government's willingness and readiness to undertake such a responsibility [73], especially as it has substantial financial implications. With more flexibility at local/county level for refugee integration, compared to the central/national levels, interventions to enhance integration at the county level should be explored and better supported.

4. Programme & Policy Recommendations

This section highlights programmatic recommendations in MCH, SRH and mental health access to services in the Kenyan refugee setting. We also provide overall policy recommendations in ensuring ease access to healthcare for refugee populations in Kenya.

4.1 Maternal and child health recommendations

Programmatic recommendations related to maternal and child health (not specific to Kenya but rather to refugee settings) suggested in literature and UNHCR reports include:

- When transportation and referral systems are not available, UNHCR's Minimum Initial Service Package [78] mandates that visibly pregnant women and birth attendants should receive clean delivery kits [79] (which contain a bar of soap, clear plastic sheet, razor blade, an umbilical cord tie, cloth and latex gloves), to facilitate safer deliveries in their camps or homes [33].
- The need for additional interventions in community outreach and targeted health promotion efforts to improve utilisation of health services and maternal outcomes in refugee populations. This includes increased community awareness and communication to refugee communities about the warning signs of high-risk pregnancies, the availability and benefit of emergency obstetric and postnatal care and referral facilities (including dispelling myths around medically required caesarean sections); and ongoing improvements in the quality of services.
- The failure of health staff to notice the severity of women's condition [30] suggests a need for the establishment of clear standard operating procedures for emergency obstetric care case management, in combination with appropriate training; and the strengthening of supervision and monitoring of emergency obstetric care services provided by partner organisations in the camps.
- For both access to neonatal and early childhood healthcare services, further community health education was cited as a key requirement. This should include, for example, information on danger signs that necessitate urgent biomedical care-seeking, both in camps like Dadaab and in urban refugee populations such as in Eastleigh. This is especially vital for serious conditions such as convulsions that may be attributed to spiritual causes. Additionally, in camps, there is a need to reduce transportation barriers by expanding emergency transport between home and the health centre beyond what is provided to labouring women, as this may encourage more timely care-seeking with sick newborns and children; and provision of interpreter services in urban populations.

4.2 Sexual and reproductive health recommendations

Specific recommendations related to SRH services and interventions in refugee settings include:

- There is little documentation of progress in provision of SRH in humanitarian settings, or of programs that effectively integrate the range of SRH services [37, 80]. This is partly because of scant information on needs and experiences of young refugees and other population groups such as the disabled, men and boys. There is, therefore, need for more work to be undertaken to document these areas.

- While the RCW model shows promise and some positive results [42]; there is need for more training and support, including in counselling and SGBV case management for this cadre of workers. There is also need to explore in depth, the roles, lives and their world views, contributions, motivations, and specific interventions that may improve (or hinder) RCW performance.
- Inability of professional SGBV service providers to communicate with refugees limits their ability to provide appropriate services [42]. There is need for training of providers on respectful communication skills; employing sign language and other interpreters in health facilities; expanding SRH awareness activities among refugee populations and reduction of wait times at facilities [38].
- While screening picks out cases of SGBV, there is insufficient evidence showing that screening reduces violence and improves health outcomes including in refugee settings, and there is need for studies to explore this [39].
- The identified studies also highlight the need for conducting follow-up visits for the survivors of SGBV, suggesting the need to position psychosocial counsellors in local health posts or immediate vicinity of those affected [39]. Caution, however, needs to be exercised in implementing this, given safety concerns for both the survivors and the workers. More broadly however, gender transformative change is required that proactively engages all stakeholders to challenge harmful gendered socio-cultural norms that make SGBV 'permissible'.

4.3 Mental health recommendations

Specific recommendations highlighted in literature on mental health of refugee populations include:

- Most of the refugee populations face socio-cultural barriers due to different cultural and religious beliefs with the host population and healthcare providers [27, 28]. For example, UNHCR highlighted challenges faced by healthcare professionals in providing support to Somali refugees, due to socio-cultural barriers and lack of understanding of specific socio-political organisation of the Somali community. Development of guidelines and description of specific refugee communities providing background and contextual information (for example, cultural profile reports on Somali refugees [52,81]) will contribute to understanding the social, cultural and religious differences of refugee populations and their interpretation of mental health illness by healthcare providers.
- Communication and language barriers between refugees and healthcare workers hinder efficient delivery of support and interventions to those with mental health illness. Strategies that can be applied include bridging language and cultural barriers through translations (by formal and trained interpreters) and intercultural orientation.
- Encouraging trust, confidentiality, and a reassuring environment in order to demystify stigma and discrimination on mental health illness. This can be achieved by improving community education and awareness through using community members to advocate for mental health awareness; ensuring health facilities have secluded areas for counselling so as to offer private and confidential environment.
- There is dire need to strengthen and build capacity of health providers through training and supervision so as to provide MHPSS services, and this will lead to more general health care workers in treating more persons with mental health disorders and community health

workers identifying, referring more cases as well as providing MHPSS [67].

- Integrating of mental health services for refugee populations within the broader health system will ensure better access and closing the treatment gap. Integrating MHPSS services is beneficial as it can be supported by other levels of care, including community health workers, has better health outcomes and is affordable and cost-effective. Commitment from government, collaboration with other sectors, development of policies, advocacy, availability of financial and human resources will be crucial in achieving integration of MHPSS [60, 61, 67].

4.4 Overall Policy Recommendations

This report summarises key gaps, challenges, existing interventions and programmatic recommendations, as highlighted in literature. There are still considerable gaps, especially in policies and their implementation in refugee settings in Kenya. In summary, the key recommendations from this report include:

- Creating a favourable political environment to facilitate the integration of refugee and host country health systems. An important step towards this is the generation of local evidence to highlight the positive effects and impacts of such integration on health and related outcomes for refugees and host communities. These might involve documenting the relevant health-related findings from the ongoing '*enhancing self-reliance for refugees and host communities in Kenya*' [76] project and similar projects undertaken within the refugee hosting counties. Additionally, the passing of the [Refugee Bill](#) (July, 2020) [82] that is currently discussed in the Kenyan parliament will also contribute to creating an enabling environment for integration of refugee and host population health systems, as Part VII on Integration, repatriation and resettlement of refugees calls for '... shared use of common social amenities between the refugees and the host communities.' (34 (1)).
- To address the unique plight faced by urban refugees to access healthcare, the Kenyan government and UNHCR should address the barriers to accessing healthcare for this population, including cost, documentation and language, as highlighted in a recent report [25]. This might include extending the NHIF card and accompanying services to all urban refugees, irrespective of their registration/documentation status. This should also be accompanied by engagement with designated health facilities within the areas where large populations of refugees are hosted on the use of the NHIF card by refugees.
- More investment in initiatives aimed at strengthening governance mechanisms within refugee settings. This would involve more engagement with informal traditional institutions, and men, to enhance buy-in in interventions involving gender-related aspects; more awareness among refugee populations, on services available e.g. on SGBV.
- Overall, improving access to basic healthcare should constitute an integral component of any self-reliance initiatives across the various refugee hosting areas. Relevant stakeholders should realise that the potential impact of any self-reliance intervention will be influenced by the general health status of the target population. The Kenyan government, the UNHCR and other major stakeholder organisations should, therefore, prioritise and support self-reliance initiatives that incorporate access to healthcare as an integral component.

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