frontiers | Frontiers in Human Dynamics

TYPE Original Research
PUBLISHED 17 January 2024
DOI 10.3389/fhumd.2023.1270524

OPEN ACCESS

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RECEIVED 31 July 2023
ACCEPTED 27 December 2023
PUBLISHED 17 January 2024

CITATION
Boeyink C, Metobo B, Wanga M, Mastaki P and Atambo L (2024) Perceptions of health: (dis)integration and (mis)integration of refugees in Nairobi, Kenya.
Front. Hum. Dyn. 5:1270524.
doi: 10.3389/fhumd.2023.1270524

Perceptions of health: (dis)integration and (mis)integration of refugees in Nairobi, Kenya

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This article utilizes 40 in-depth interviews of healthcare workers (HCWs) including Kenyan nurses, medical doctors, psychologists, pharmacists, refugee NGO officers, and others based in Nairobi who come in professional contact with Congolese and Somali refugees on a regular basis. They were asked to describe barriers to healthcare, care seeking behaviors, and pathways to care that refugees experience. These responses are juxtaposed with 60 life-history interviews, exploring the same topics with Congolese and Somali refugees living in Kawangware and Eastleigh estates. In short, this article argues that refugees and HCWs have a shared understanding of the barriers to healthcare for displaced people, such as poverty, refugee documentation issues, and inadequacy of Nairobi's healthcare system for marginalized populations. However, there is a significant disconnect in perspectives for how healthcare integration should take place regarding major causes of ill health, such as malnutrition and poor hygiene. Refugees understand oppression as a primary structural determinant of health, whereas many HCWs take an individualized view, advocating for modifications of knowledge and behaviors of refugees rather than adjusting structural issues. This is reflective of larger processes, whereby refugees are actively "(dis)integrated" by state and society and are observed by many Kenyans as "(mis)integrating," or integrating "wrongly" or "badly," which has major implications for how to shape possible policy interventions.

KEYWORDS

Nairobi, refugees, Congolese, Somalis, barriers to healthcare, perceptions of health, structural determinants of health, integration

Introduction

Kenya is currently hosting nearly 600,000 refugees and asylum seekers[1], though these numbers are indefinite estimates. Most refugees reside in two camp complexes—Kakuma and Kalobeyei in the Northwest and Dadaab in the West, while an estimated 100,000 refugees reside in urban areas.[2] Despite the long-running encampment policy of the country forcing

1 For shorthand, we will use the term refugees, despite many displaced many individuals in Nairobi having asylum-seeker status or being undocumented altogether.

2 https://data.unhcr.org/en/country/ken

refugees to live in camps since the 1990s, thousands have left the camps, or bypassed them entirely, due to the lack of economic and educational opportunities or escape the violent containment of encampment (Brankamp, 2019) to make their way to Nairobi, where there are more options for livelihoods and healthcare. Focusing on Congolese and Somali refugees residing in Nairobi, in a context where refugees have been actively excluded through securitized and punitive refugee policies, this article explores multifaceted processes of integration through the prism of healthcare.

The question animating this inquiry is how integrated into the healthcare system are refugees? Because integration is simultaneously done *by* and *to* refugees, we examine this process by analyzing the care-seeking behaviors and perceptions of causes of ill health among Nairobi refugees as perceived by refugees and frontline Kenyan healthcare workers (HCWs) as one key interlocking component of integration. In short, this article argues that refugees and HCWs have a shared understanding of the barriers to healthcare for displaced people, such as poverty, refugee documentation issues, and inadequacy of Nairobi's healthcare system for marginalized populations. However, there is a significant disconnect in perspectives for how healthcare integration should take place regarding major causes of ill health, such as malnutrition and poor hygiene. Refugees understand oppression as a primary structural determinant of health, whereas many HCWs take an individualized view, advocating for modifications of knowledge and behaviors of refugees rather than adjusting structural issues. Speaking with the literature of migration and integration, we argue that refugees see themselves as systematically "(dis)integrated" from healthcare (Collyer et al., 2020), whereas HCWs see refugees by what we term as "(mis) integrated" or "wrongly" integrated due to their behaviors or lack of understandings. These perspectives of (dis)integration and (mis)integration mirror longer histories of migration and exclusion of migrants and refugees in Nairobi and xenophobic perceptions of the Kenyan host society.

Through surveys, in-depth interviews, and life histories, we ask refugees and HCWs what they perceive to be the primary causes of ill health, the rationales for care-seeking strategies, and the largest barriers to finding adequate care. This article is divided into five main sections. First, we outline the methodology of the project. The second section has two subsections, which provides context of the refugee situation in Kenya and Nairobi, including refugee policies and backgrounds on Somali and Congolese refugee populations, in particular. It introduces the myriad barriers refugees face to access the healthcare system in Nairobi. Third, we briefly analyze theories of integration. We argue against an individualized, outcome-based usage of integration; instead of using novel terms (dis)integration and (mis)integration, we make the case that integration is best understood as a structural process, where refugees negotiate and contest normative notions of how one "should" integrate. The fourth section expands on the integration arguments by empirically comparing refugee and HCW perceptions on health. We contend that refugees understand structural marginalization, or (dis)integration is a primary driver of health, whereas many HCWs see refugees (mis) integrating or integrating wrongly through individual actions or lack of knowledge on hygiene and malnutrition. The concluding section synthesizes the data through the prism of integration and possible policy considerations.

Methodology

This study is a part of a wider project exploring displacement and health at the intersection of gender for displaced Congolese and Somalis in DRC, Somalia, Nairobi, and Johannesburg, South Africa. While many nationalities reside in Nairobi and Johannesburg, Congolese and Somalis were the two largest populations in both locations, which offered the opportunity for comparative analysis across all sites. Moreover, Congolese and Somalis differ socially and culturally in that Congolese are majority Christian and Somalis are majority Muslim, with both speaking different first languages. In Nairobi, Kawangware and Eastleigh were chosen for the high number of Congolese and Somali refugee residents, respectively. Data collected for this research included quantitative and qualitative methods—although this article primarily engages with qualitative interviews. Participatory "social connection"[3] workshops were used to explore what people, organizations, or institutions displaced people turn to when experiencing disruptive mental health problems, physical pain, or sexual and gender-based violence (SGBV). The workshops created and distilled lists of the 30 most relevant social connections, which was followed with a survey of 886 individuals older than 18 years (roughly half participants having Kenyan citizenship) using Kobo Toolbox on mobile devices. The survey collected basic demographic information and asked the participant their level of trust, amount of contact, and frequency of reciprocal help they have given to each of the 30 social connections.

At each survey, the participants were subjectively evaluated by research assistants (RAs) on a subjective five-item scale determining their cooperation and eagerness for engagement in future in-depth interviews. In total, 60 participants (30 Somali and 30 Congolese) scoring 4 (high) or 5 (very high) were selected and consented to give in-depth life history interviews. The informants were asked to describe their displacement and health histories, what they thought caused ill health, care-seeking behaviors, and barriers to care. After difficulty accessing informants, interviews were conducted in health clinics with the support of community health volunteers (CHVs). This gatekeeping likely biased the sample as the participants were at least in some contact with these volunteers and/or clinics and would likely be of lower income than those who access private clinics and do not necessarily represent the experiences of all refugees.

Additionally, 40 key informant interviews were conducted from the list of social connections created from the workshops. These individuals included Kenyan HCWs such as nurses, medical doctors, psychologists, pharmacists, from private and public facilities, and refugee NGO officers who come in regular contact with refugees. To aid in building trust and facilitating communication, the interviews were conducted in the preferred languages of participants such as Somali, French, and/or Swahili by research assistants (RAs) who were Congolese nationals, ethnically Somali (some had refugee status and others had Kenyan citizenship), and one non-Somali Kenyan who spoke Swahili and Arabic. All interviews lasted between 30 min all the way to an hour and a half. Interview data were audio recorded with consent and translated and transcribed in English. The data were

3 See Strang and Quinn (2021) and Boeyink et al. (2022) for more details on these methods.

coded and analyzed using TAGUETTE software. The codebook was agreed upon by the research team, and two RAs coded using various themes, such as certain health conditions, types of barriers to healthcare, types of healthcare providers, causes of illness, livelihoods, documentation, and many other relevant themes. Review of the coding by the authors informed the arguments of this article.

Ethics was approved by [University 1], [University 2], and Kenya's National Commission for Sciences, Technology, and Innovation (NACOSTI). Each researcher participated in training on ethics and safeguarding. All participants were read, provided, and consented to information sheets and promised confidentiality. Finally, in consultation with a psychiatrist, the research teams were trained how to sensitively approach potentially distressing research and set up processes of support, or mental health first aid, to cope with difficult research. Although the interview guide did not contain questions dwelling on potentially distressing personal experiences, some participants shared painful stories. As such, a referral pathway was set up for intense distress. Counselors of NGOs were made available for participants who felt the need for counseling or psychological support. Many of these painful stories recounted by the informants stem from the marginalization they face by the Kenyan state and society, which is outlined in the following section.

Displacement and health in Nairobi

Since the 1990s, the Democratic Republic of Congo (DRC) and Somalia have been plagued by major wars and long-simmering conflicts exacerbated by poverty and natural disasters, leading to the displacement of millions to Kenya and surrounding countries. Kenya, like other East African countries such as Tanzania, received such large numbers of displaced people, which resulted in instituting a highly securitized encampment policy, where refugees do not have the right to free mobility or formal employment outside the camps. While previously administered by the government and Kenyan organizations, camps came to be governed and managed by the UN High Commissioner for Refugees (UNHCR) and other international organizations and NGOs (Kagwanja, 2002; Milner, 2009). This segregation is a key example of "(dis)integration" of refugees in Kenya, which will be further examined below.

Despite this prohibition of refugee movement, thousands of refugees have moved to Nairobi, pushed out by poor camp conditions, and drawn by possible livelihoods and freedoms of the city. Refugees have historically been required to live in camps; however, because such large numbers of refugee have migrated to Nairobi, this population is locally tolerated to a degree, which causes legal ambiguity and barriers to integration. This is a prime example of "(mis)integration"—the processes in which refugees integrate in ways contrary to what is desired by the Kenyan state and much of its population. Currently, refugees must register with UNHCR and the Department of Refugee Services (DRS), although this is a highly bureaucratic process that is time-consuming and costly. Many do not register or renew documentation, or their attempts are delayed or given up on altogether (Pavanello et al., 2010; Graham and Miller, 2021). There is some optimism for a change in direction for Kenya's refugee policy after the passage of the Refugee Act 2021, which is being described as the "Marshall plan of Africa" (Malik, 2023), though the implementation is still ongoing and it is unclear how progressive this policy will be in the end (Leghtas and Kitenge, 2023). These changes are not yet reflected in the Nairobi County Integrated Development Plan 2023–2028 (Nairobi City County, 2023).

Even with proper documentation, it is nearly impossible to acquire a work permit, which leaves the only possibility for livelihoods in the informal economy or through those with access to remittances abroad, resulting in highly precarious income. Most Kenyans also work in the informal economy, although there are at least pathways to acquire permits if they have the resources. This legal ambiguity has led to refugees in Nairobi, with or without documentation, to fall prey to predatory police services who solicit bribes. This is true for many Kenyans, although refugees and migrants face the elevated threat of detention and/or deportation.

Somalis have had contentious relationship with the Kenyan state and society since colonialism, which has resulted in suspicion, xenophobia, and periods of collective punishment (Boeyink, 2017). In essence, Somalis have a history of being both (dis)integrated by the state and (mis)integrating themselves into society in enclaved ways. One way this is manifested by Somali refugees, facing insecurity from Kenyan security forces, as mentioned above. In a sense, Somali refugees are an easy target for discrimination. First, many Somalis live in the Eastleigh estate, known as "Little Mogadishu" because it is an area of Nairobi where Somalis have resided for a long time (Campbell, 2006; Carrier, 2016). Second, we say this cautiously to not reify ethnic and racial stereotypes; Somalis in Nairobi are often believed to look identifiably different to most Kenyans due to particular phenotypical physical characteristics. Moreover, Muslim dress, especially the common headscarves of women, present aesthetic markers that stand out differently than Congolese and other non-Muslims. On the other hand, Congolese "blend in" as they are more dispersed across the city, primarily in informal settlements such as Kawangware. This population is more spread out because eastern DRC is more ethnically and linguistically heterogenous and fractured, and there is not a densely populated area such as Eastleigh from which people can settle in and find co-ethnic support.

Somalis and Congolese also differ significantly in their socioeconomic integration into Nairobi. One significant study found that while fare of Somali refugees similar to Kenyan citizens in terms of incomes and other metrics of wellbeing, Congolese outcomes are far lower than Somalis and Kenyans. However, incomes of Somali women are nearly half of that of Somali men in the refugee community, which shows how highly gendered vulnerability is in this context (Betts et al., 2018, pp. 16–20). Many people make their way to Nairobi without resources or the social connections they have severed upon arrival and for various reasons struggle to integrate economically (Boeyink, 2017). For example, a Congolese woman fled in 2014 due to a massacre occurring near her village. In the chaos, she was separated from her husband and boarded a lorry hauling lumber to Kenya with her 2-month-old baby. She did not know anybody when she arrived in Nairobi.[4] Similarly, a Somali woman described leaving Somalia with her grandmother to live in Nairobi. Shortly after arriving, her grandmother died and she bounced around living conditions until she was forced to marry a man at 19 years old. She is now economically dependent on this man but has no other reliable

4 Female Congolese refugee, Nairobi.

connections in the city.[5] The economic precarity demonstrated by these women and many other refugees is a key factor, excluding them from the healthcare system in Nairobi.

Refugees and healthcare

In the academic literature on refugee healthcare in Nairobi—from general overviews of refugee healthcare (Pavanello et al., 2010; Arnold et al., 2014; Jemutai et al., 2021; Mohamed et al., 2021); studies about access to mental health (Tippens, 2017; Mutiso et al., 2019); sexual, reproductive, maternal, and new-born health (Lowe, 2019; Lusambili et al., 2020); as well as following female genital cutting (Kimani et al., 2020)—there is nearly universal agreement about the main barriers to healthcare for refugees in Nairobi, which we build in the empirical section below. These obstacles include poverty, gaps in affordable healthcare services and supplies, refugee documentation, and discrimination. Issues of healthcare costs and poverty stand as the biggest impediments to care. One study shows that 95% of refugee participants citing costs as a barrier to accessing healthcare (Muindi et al., 2019). Arnold et al. (2014) importantly note that, apart from documentation and migrant discrimination, these barriers are also faced by Kenyans who do not have the means to pay for adequate care, which offers clear evidence of the structural inequality of the healthcare system. Despite the barriers to care, as Nairobi is one of the economic powerhouse cities in Africa, quality healthcare does exist. Moreover, there are free services offered by government clinics and hospitals as well as NGOs. However, this is a patchwork of care, which does not come close to reaching the myriad needs of such a large and marginalized population. One large study found that 43.7% of the study participants received help from an NGO, and only 12% of these had received medical support (Muindi et al., 2019).

As mentioned, there is an established base of literature clearly agreeing the gap in experience of healthcare refugees. With few exceptions shown below, however, most of this research do not ethnographically and qualitatively explore the everyday lived realities, perceptions of care, or healthcare pathways that refugees experience in trying to access care or choosing to abstain from certain services. Moreover, there is little discussion in this literature of the structural oppression as a determinant of ill health for refugees in Nairobi. Recent study in this special issue by McAteer et al. (2023) follows the medical pathway of a displaced individual as he navigates private and public clinics and his own personal networks to bring the inadequacy of services to life. This research shows that only well-resourced and connected individuals and families can navigate this complex terrain. Research by Lowe (2019) on maternal health of Somalis in helps illuminate the cultural disconnect between Somalis and HCWs in Nairobi. She explores the frustration and bafflement of policymakers and doctors when Somalis defy expectations such as leaving free healthcare in refugee camps to seek more quality care of private facilities in Nairobi or when Somali women refused cesarean births against medical advice.

Julie Tippens, building on conceptualizations of structural violence and vulnerability, is the most explicit in her critical stance:

> In the sociopolitical context of Kenya, in which urban refugees have become abruptly illegalized and peripheral, psychosocial wellbeing is contingent on navigating and negotiating health-promoting resources in a limited and ever-changing landscape. The exertion of violence against urban refugees in Kenya is indeed patterned; however, violence is enacted within a fluid environment: everything, from the enforcement of laws to the stability and composition of the household unit, is subjected to change. The only certainty is uncertainty, and this precariousness is the crux of structural vulnerability (2017, p. 1091).

We share the view with Tippens, adding that this structural marginalization is reflected also in poor nutrition and hygiene among refugees, which leads to poor health outcomes. We make the case below that perceptions of HCWs in Nairobi observe lack of information or awareness as determinants of ill health—mirroring the public health literature in this section—which minimizes structural oppression as drivers of illness. Furthermore, similar to the study by McAteer et al. (2023) and Lowe (2019), we take a ground-level view of refugee and Kenyan HCW perceptions to highlight disconnects in structural understandings experienced between these two groups. It is against this backdrop that we critically examine integration, where refugees are actively excluded spatially, economically, and socially. These exclusions profoundly affect access to healthcare, yet refugees find ways to make homes in ways contrary to the way the Kenyan state and society normatively deem acceptable.

Integration and care-seeking

Integration, (dis)integration, and (mis)integration

Integration is a complex, multidirectional process involving all aspects of society where migrants and refugees act to integrate themselves into a society (or not) and are simultaneously acted upon by actors and institutions within a society to be integrated (or not). The influential study by Ager and Strang (2008) notes that there are important "domains of integration," of which health is one of the many factors. This view, when operationalized into measurements of scales of integration, narrows the concept of integration as an individualized outcome. We hold the view with others that integration is a societal process rather than an end state (Collyer et al., 2020; Spencer and Charsley, 2021). In this section, we examine the attempt of one study to quantify integration and challenge its aggregation of domains of integration. We use this as a justification to focus on the processual exclusion of refugees from healthcare in Nairobi, which points us toward the concepts of (dis)integration and (mis)integration.

Beversluis et al. (2016) build on the framework by Ager and Strang (2008) on integration to create a 25-point "refugee integration scale" (RIS) using Nairobi as a pilot to test its validity and reliability. In their efforts, the scale asks 25 questions in the following domains of integration: (1) language and cultural knowledge (three questions); (2) safety and stability (four questions); (3) social bonds (one question); (4) social bridges (three questions); (5) social links (three questions); (6) employment (four questions); (7) housing (two questions); (8) housing; (9) health (one question); and (10) rights and citizenship (three questions). Each indicator is weighed four points for a total of 100:

5 Female Somali refugee, Nairobi.

> Through attempting to quantify integration on a scale ranging from 0 to 100, we do not intend to imply that there are absolute end points to either—that a person who scores 100 has achieved a clearly defined status of "fully integrated", an end point at which the process of integration stops. Similarly, a score of zero does not imply the lowest possible level of integration. Rather, we assign a number to an individual's level of integration, acknowledging that the absolute numerical value is arbitrary and has limited inherent meaning, but can allow comparisons between individuals and groups over time and place […] we have chosen to target this scale at an *individual's* level of integration. We do not target household or general community for responses, although an aggregate measure of individual responses may be useful in analysis (p. 118).

While this quote acknowledges the limitations of quantifying individualized integration, we argue that this framing obscures interlocking structural oppressions that refugees in Nairobi (and elsewhere) face in general. More specifically, its methodology inherently minimizes the importance of healthcare in processes of integration. For instance, the one question about accessing health states: "I am permitted to access health care services for me and my family just as easily as our Kenyan neighbors." First, the wording around "permitted" obscures *de jure* and *de facto* exclusion. As we demonstrate, refugees are "permitted" to access a range of health services that Kenyans are, but in practice are excluded based on costs and discriminatory practices. Second, having only one question on health minimizes the importance of wellbeing as an indicator of integration. For example, if someone suffers from ill health of a certain magnitude, this affects all other aspects of integration such as seeking livelihoods. From a policy standpoint, healthcare has also been deemed a priority for UNHCR and the Kenyan government, as evidenced by its inclusion in the CRRF as a key priority area and should be considered as a crucial component when conceptualizing integration (O'Callaghan et al., 2019). Moreover, as many questions ask refugee participants to compare themselves with their Kenyan neighbors, this also obscures the sociospatial aspect of poverty in Nairobi. Most refugees in Nairobi live in poor informal urban settlements, which exclude analysis of the spatial exclusions of estates and neighborhoods from other areas with greater access to wealth and power. While the RIS may be useful in diagnosing degrees of inclusion and exclusion, particularly when aggregated and compared across ethnicities and nationalities, this points to the causes of integration or analyses of power, which intentionally disintegrate certain groups.

To explore these dynamics of politics and power, we draw from the collection, *Politics of (Dis)integration* (Hinger and Schweitzer, 2020). They define integration as a "set of normative assumptions, practices, policies, and discourses that are always embedded in specific contexts and directed at particular groups or categories of people […]. The context and perceived desirability of integration of migrants and minorities ultimately depends on how they are categorized by the state in which they live" (Collyer et al., 2020, p. 2). Contrasting this, they use disintegration as a "coming apart of society," with the purpose of exclusion for certain groups: "disintegration policies and practices do not only overlook settlement but also actively set out to do harm and discourage it, although they are sometimes justified within a broader integration framework" (Collyer et al., 2020, p. 2). It is important to note that integration and disintegration are not merely opposites but co-constitutive of one other: "integration and disintegration are not a simple binary categorization but are intertwined in that the logic of one is always present in the other. This connection is sometimes explicit, often implicit but ever-present in migrant lives. We use the notation (dis)integration to describe this intertwining" (Collyer et al., 2020, p. 3). The (dis)integration of refugees in Kenya is clear through the policies of spatial segregation through encampment, the *de facto* enclaving of refugees in poor informal settlements in Nairobi, and the exclusion through documentation obstacles to accessing employment and healthcare.

Continuing this prefix wordplay, we introduce the term, "(mis) integration." Scholars exploring integration are often criticized for the normative connotations that integration brings. Policies and discourses of integration are often accused to normatively suggest what migrants and refugees *ought* to do or that they *should* assimilate to achieve a desired integration outcome (Spencer and Charsley, 2021). We take this conceptual fuzziness head on by adding the prefix, "mis-", which is a prefix meaning "badly" or "wrongly." Integration is fundamentally relational and "in the eye of the beholder." By using (mis)integration, we can empirically identify where actors are normatively setting out how they perceive integration should take place. For this article, the ideal integration from the perspective of the state or HCWs may differ significantly from a refugee from DRC or Somalia. (Mis)integration represents this relational framing. Thus, when a refugee in Nairobi integrates into society in ways the state or HCW perceives as "badly" or "wrongly," this constitutes refugee (mis) integration. Research by Lowe (2019) on maternal health of Somalis in Eastleigh mentioned in the previous section is a prime example of (mis)integration and healthcare, where Somalis interact with the healthcare system in ways contrary to what is expected of them. We analyze this concept further below in our discussion of poor nutrition and hygiene among refugee populations. Many HCWs observe these as behaviors in need of correction through awareness raising. In other words, they are perceived by many HCWs to be (mis) integrating into Nairobi through their (in)actions, whereas refugees observe their structural (dis)integration into accessing adequate food and clean environment.

Results

Barriers to refugee healthcare

On the ground, the interviews with refugees and HCWs confirm and deepen the consensus that refugees face many obstacles refugees face in accessing care. One Somali refugee succinctly summarizes the issue: "Poverty is the main underlying factor contributing to the poor health conditions in the community." If you are poor, it means that you cannot settle your medical bills.[6] Another Somali refugee reflects on the difficulties and stresses the lack of documentation brings: "In the country, you are given nothing, documentation, and other life aspects, you are disturbed so much. If you move you will be detained, the security officers will arrest you and you will not be excused for saying am a refugee, that will not work. Am someone who has been

6 Female Somali refugee, Nairobi.

suffering and burdened more."[7] Innumerable others describe a situation where they went to a hospital or clinic and needed a specific treatment, scan, or surgery but could not receive it because they could not afford the specialized care, thus exacerbating their issues. HCWs concur with this assessment. A psychologist states,

> Lack of finances is another issue, we find that if it's too far to reach, since you don't have that money for transportation, you would rather go to whatever chemist is next to you and get medication because if you have to go to Huduma [government service center], it will cost you going all the way to Huduma. So there's finances issues—actually finances is number one.[8]

This HCW notes the geography of (dis)integration in Nairobi. Refugees reside away from many of the key services and cannot even afford transportation—and the risks of police bribes along the way. Even if they make it to the Huduma government service center, they must navigate the broken asylum documentation bureaucracy. Another Congolese woman bluntly assesses the inequity in the health system for refugees:

> We have diseases out here. Someone who can become sick, then they remember the stress they get at hospitals, they just stay with it and don't go to hospital. They should help us, take care of us and give us good people, so that we feel loved, even when we get to hospitals, we don't see a difference. A refugee that loves Kenya is one with money and has capability, they are the ones who know Kenya's importance, but refugees like us, you just hear, better to stay home.[9]

This woman agrees with the psychologist about the difficulty of paying for transport, but there are even more barriers involved. Asking to be given "good people," the informant here is joining many others in describing discrimination from administrators and practitioners at the point of service. She recognizes that for those refugees with the resources, Nairobi is a great place to access to care. For the rest, they are dejected to the point of abstaining from care-seeking altogether.

In a wide-ranging interview with a HCW at a free health clinic in Eastleigh, this participant aptly summarizes how challenges for refugees described above lead to poor uptake in services and health outcomes, which suggests widespread and systematic (dis)integration:

> You realize that most of the migrants that we have, or the refugees that are there are undocumented, and if they're undocumented, they don't easily come out of their homes, especially even when they're sick. They fear when they go to the facilities that they will be asked for ID or some registration document, which they may not be having, and somebody will bring the police or cause an alarm, such that they will be displaced or deported back to their homes. They have poor health seeking-behavior especially because of the legal status, where they live. Number two, some of them they have a language barrier […] Also, they also have a challenge in access to continuity of care. For example, if somebody started on anti-[tuberculosis medicine] today, and for one reason has to go back to their home countries in Ethiopia, then that TB care stops there the next day, or in somewhere in north-eastern the next day, or somewhere else hiding from the authorities. The continuity of care, and also the outcomes of these patients is usually not very good, especially for diseases which have long term care […] Lastly, I would say, financing, if you cannot access work, you cannot be able to pay for a service. Most of the health services are quite costly, so the fact that they don't have access to insurance is a problem you see.[10]

This HCW worker covers a lot of ground. He discusses the issues of documentation, policing, language barriers, the precarity of forced mobility to their country of origin and elsewhere, which disrupts continuity of care, the high costs of care, and inaccessibility of NHIF health insurance for most refugees. There are myriad inhibiting factors leading to poor health outcomes and suggesting that larger systemic issues are impeding healthcare integration. This is agreed between refugees and HCWs.

As mentioned, these barriers are well known by policymakers. In principle, there are healthcare services and programs that refugees are entitled to designed to mitigate these barriers, including the National Hospital Insurance Fund and free public and NGO-funded clinics and hospitals. Unfortunately, there are major gaps in their functionality and availability to refugees. As part of the Comprehensive Refugee Response Framework (CRRF), a global push for piloting enhanced refugee protection, UNHCR worked with the already established National Hospital Insurance Fund (NHIF) to integrate refugees into the social protection system. This program, available to Kenyan citizens, offers health insurance targeting "vulnerable" households to access many healthcare facilities. UNHCR pays KES 500 (USD $5) each month per household and, by 2019, sponsored approximately 8,000 households (Maara, 2022). An "alien ID card" or UNHCR document known as the "mandate" is required for eligibility, which is difficult to obtain as demonstrated. For well-connected and knowledgeable refugees who are up to date with their documentation, this insurance is very helpful, as described by a Congolese woman:

> We as refugees get many opportunities to be treated for free, sometimes getting free medicine when you are sick and organizations writing a letter for you. There's this card you get called NHIF. As a parent, you can go and give birth, even when you are sick and the bill becomes high like when you are admitted, you share the bill with UN, you pay half, and they pay the other half.[11]

A different Congolese woman is even more direct about the NHIF: "We have good access [to healthcare] especially if you have money, they'll treat you well like anybody else or if you have the NHIF card that they gave us. Like I can say, I used my card when giving birth to my last child. I did not pay anything. I just paid 300 for subscription and everything else was free."[12] Conversely, a Somali woman in Eastleigh states the difficulties without the NHIF card, which refers to

7 Male Somali refugee, Nairobi.
8 Psychologist, Nairobi.
9 Female Congolese refugee, Nairobi.
10 Medical doctor, Nairobi.
11 Female Congolese refugee, Nairobi.
12 Female Congolese refugee, Nairobi.

as "the UN card": "If you had the UN card it was not hectic, you could go to any hospital that you want. If you do not have the card from UN, you can be prescribed for an expensive medication and you cannot afford to buy."[13] Moreover, many participants who were able to obtain an NHIF card, describe the sponsorship ending without having payments being made by UNHCR or other NGOs: "UN used to pay [for NHIF] on our behalf, but they later told us to use our own money. I sometimes could not get the 20 shillings to deposit in the card and I did not go for the re-registration."[14] This is confirmed by a HCW based in Kawangware:

> We deliver healthcare to NHIF card holders but not to everyone. It depends on how many the donor has recommended. After we offer them, once the year is over, we are not able to pay for the NHIF again. The card become useless because you have to pay for it again. For most refugees they lack finances, they have no money to seek medical healthcare. They have no insurance and the ones who have are very few who will not be able access if their cards are not paid for.[15]

Finally, we heard accounts that many healthcare providers turning away NHIF cards in favor of cash (Muindi et al., 2019), which was confirmed by HCW informant at a maternity dispensary.

There are also free clinics offered by public, religious, or NGOs across the city, some of which refugees are entitled to (depending on available documentation). The main issue is that providers readily admit that their services and availability of medicine are severely limited, which pushes care-seekers to the expensive private health sector. One HCW at a free clinic in Eastleigh describe how the demands for care far outstrip the supply:

> Here, we give free services. That means the lab is free, consultation is free. Even meds you get them free […] So, what normally happens is that when the refugees know that the medical stock has come, they come to the hospital collect medication to keep with them at home to use when one falls sick. As a result, they get out of stock very fast. The IOM [International Migration Organisation] did a budget for like one year, but let me surprise you: The stock they bring won't even last for one week. […] We can even go like for even three to four months without the supply. Around here, I think we are the only ones offering free services.[16]

This quote is notable not only because the supply of medications did not last but also there are very few free alternatives in the area. Both refugees and HCWs alike recognize that they have succeeded in providing free or affordable initial consultation or diagnostic services, yet the next steps of medication or treatment are unaffordable as described by a HCW of a free clinic in Eastleigh: "If you prescribe a drug-like Augmentin [antibiotic], it goes for almost six hundred, so they will not buy, they will only buy a painkilling and they keep on coming back with the same issues."[17] As demonstrated in the research by McAteer et al. (2023), in the absence of free and affordable care, refugees must deal with the economic shock of paying for private care, deal with the immense complexity of the healthcare system, or remain untreated, which significantly impairs other aspects of integration such as employment and housing. When HCWs, often community health workers, observe refugees lacking financial means, they will refer them to NGOs which offer livelihood, legal, documentation, health, and education supports.

Perceptions of health

Broadly speaking, when we asked refugees what causes poor health for them in Nairobi, they cited the environmental conditions of forced precarity due to legal limbo and poverty. Many (though not all) HCWs instead individualized illness, blaming refugees' lack of knowledge or specific behaviors leading to poor health. We observe stark parallels to the economic development maxim, "give a man a fish, and you feed him for a day. Teach a man to fish, and you feed him for a lifetime," which was provocatively challenged by anthropologist James Ferguson:

> Those more oriented to political economy have noticed instead the suggestion that poverty derives from a primordial ignorance on the part of the poor and have observed that poor people are in fact far more likely to lack the material means to enter an occupation like fishing (boats, motors, nets, and access and rights to waterways) than they are to be held back by a lack of knowledge (Ferguson, 2015, p. 35).

He goes on to attribute poverty to a problem of distribution due to the decline in the efficacy of labor as a poverty salve. We contend, however, that healthcare experts and practitioners in Nairobi take up the development and public health trope that hygiene and nutrition are an issue of knowledge and expertise, whereas refugees share the view of the political economists that these issues are more caused by lacking material means.

Structural determinants of health

Beyond blocking access to adequate health facilities and treatments, refugees are keenly aware that structural urban poverty is intersectionally compounded by gender and displacement. (Dis) integration of refugees from the formal economy by government and Kenyan society is the cause of poor health in the first place, particularly around the issues of mental health, malnutrition, and hygiene; however, it begins with a lack of income, which is a point made by a Congolese woman: "Money can help us a lot. Tell those people that we want them to assist us financially. It is difficult to pay rent, to get food so if you help us well, we shall be happy […] The problem is totally lack of money."[18] A Congolese man also made the connection between the environment and poverty: "The cause I can say is first adapting to the weather. Then dealing with, let us say for example, this June is cold, so, a refugee cannot afford to buy a sweater because they do not have money. The cold hits them on the chest then maybe they get pneumonia. They do not have ways to deal with what can give

13 Female Somali refugee, Nairobi.
14 Female Congolese refugee, Nairobi.
15 Counseling psychologist, Nairobi.
16 Healthcare administrator, Nairobi.
17 Health administrator, Nairobi.
18 Female Congolese refugee, Nairobi.

them infection."[19] The colder months of Nairobi were commonly referenced by others as significant causes of illness. With lack of incomes, they could not have adequate shelter and clothing to deal with this perceived determinant.

A Somali woman joined others in pointing to the profound stressors caused by the effects of poverty: "Other factors include lack of clean water, insomnia and anxiety which also come as result of poverty."[20] People constantly worry where their job and meal will come or how they will afford education and health fees for their family. This could compound already existing trauma of war and displacement present that refugees might experience. A Somali man expresses the depression that results from joblessness:

> What causes the depression is lack of jobs. When a person is jobless, they will talk to themselves, they will say to themselves, my peers are working, there's no one to hold your hand, you have been educated, you hide it from your family. If you sit in front of your mother and father, you have been educated, you are not working, so, you tell yourself you are the one who is depressed, so, don't bring that to your parents. There are some people who even kill themselves or hang themselves because of the severity of unemployment-induced anxiety and stress.[21]

This quote importantly points to the disruptions in career paths and the social and familial pressures of economic success. Despite education, meaningful work is severely impeded by displacement. This leads to how another Somali man evocatively describes life coming to a standstill due to poverty and (dis)integration of refugees in Nairobi:

> The problem refugees face here is employment, not being able to reach where the person needs to visit because he cannot go. You cannot even marry. There is nothing you can do for yourself. You cannot go to a region outside Nairobi for whatever reason. There is a lot, we are in jail that seems no one knows about. You have no opportunity to work because it is only through informal means but there is no official work you can do. There is no place you can work; you can do nothing. You are someone overtaken by the status since you don't live in your own residence, everywhere you rent which is expensive. It is like a hectic, hell of life.

This "hell of life" described above resulting from poverty and displacement prevents key rites of passage and sources of joy and belonging such as marriage, travel, fulfilling work, and home ownership led to a feeling of life incomplete. However, even those who are able to establish a family and have children, poverty and marginalization cause significant stress due to unfulfilled gender and care expectations for both men and women as described by a Congolese man:

> Even the men are not exceptional because they provide for the children in terms of accommodation, health, etc. If he cannot afford, he gets stressed. But when the mother is a single parent, she bears both responsibilities which results in stress and being poor. When someone does not have enough medication, worry and stress multiply. You will fall sick because you cannot help. You cannot help your relatives and family and there is no fundraising, rent and other ending aspects of livelihood. It is a very difficult matter and whoever can comprehend, it is not easy. So, it has a lot of impact on us.[22]

Although we lack the space to expand analysis here, this informant's analysis of the gendered experiences of displacement fit what scholars in many other displacement contexts engage with. There are different pressures to provide income and care with men often expected to be the breadwinners and the stress and existential disappointment when they cannot. The informant is also attuned to the intersectional experience of poverty that single mothers face when they must provide and care and struggle to do both due to disruption of networks and (dis)integration brought by displacement (Fiddian-Qasmiyeh, 2017; Buckley-Zistel and Krause, 2022).

Beyond just identifying the prevalence of stress or "pressure" as many informants describe, there is also an acute awareness of the somatic manifestations this stress brings. Many recognize that high stress, depression, and anxiety can cause headaches, hypertension, ulcers, and other bodily pains. In addition to describing instances of suicide, a Congolese man discusses severe harm he believes comes from the daily financial stressors: "My friend died of a heart attack because of lacking what the children will eat, something like that. All this is brought about by lack of money. I think those are the things that bother people the most."[23]

Beyond poverty causing severe stress and psychosomatic fallout, many refugees recognize that poverty leads to nutrient deficiencies and difficulties in sustaining hygiene, which contributes to poor health. For instance, a Somali refugee in Eastleigh explains directly, "Poor health is caused by poor sanitation, polluted water. Most people complain about consumption of polluted water. Moreover, people throw garbage anywhere, this affects people's health."[24] A Congolese man echoes this as an issue in Kawangware when asked about hygiene of fellow refugees: "It depends on your surroundings and the living spaces. For instance, the slums. Even in Kawangware, the sewer waters and remnants were all over and people were just eating there in those shacks like restaurants."[25] This individual recognized the spatial segregation of informal settlements, which most refugees and other marginalized poor Kenyans are relegated to is a central environmental determinant of health, which is a key aspect of the (dis)integration of health.

Regarding nutrition, when asked for the reasons of the most common illnesses among refugees in Nairobi, a Congolese man attributes sees poor diets caused by poverty to be a primary driver: "I think it depends on their diet and nutrition. People eat whatever is affordable. They eat the same food all the time."[26] Finally, another

19 Male Congolese refugee, Nairobi.
20 Female Somali refugee, Nairobi.
21 Male Somali refugee, Nairobi.
22 Male Congolese refugee, Nairobi.
23 Male Congolese refugee, Nairobi.
24 Male Somali refugee, Nairobi.
25 Male Congolese refugee, Nairobi.
26 Male Congolese refugee, Nairobi.

Congolese man summarizes the structural constraints of nutrition and hygiene:

> First of all, the community needs to get food. Getting food helps prevent a lot of illnesses. If they get good food and a place to live where they do not have mosquitoes, it will help. Illnesses will reduce. If they have good food, a good dwelling, and clean water, it will prevent illnesses. However, if they get medicine but they do not have food, they will still get sick. If they do not have money, they will drink water from wherever, they have no choice. We need to take preventive measures instead of treatment. We should protect these people from diseases.[27]

The quote of the interlocutor elucidates the interlocking deficiencies that stem from poverty and displacement. He recognizes that even if somebody gets access to care and/or medicine—which we have demonstrated is difficult to obtain without resources—the structural and spatial environment, where adequate shelter, clean water, food availability, and protection from mosquitoes are difficult to come by, will lead to continual recurrence of illness. When these questions about the determinants of health were asked of HCWs, we received significantly different answers, focusing on individual responsibility and knowledge as causes of illness rather than structural oppression.

Individual determinants of health

Recalling Ferguson's discussion of philosophies of development, HCWs take more of a "teach a man to fish" approach to public health for refugees in Nairobi compared with the political economy philosophy of refugees. Many HCWs take the view that refugees are (mis)integrating, or not integrating correctly, by their choices and lack of knowledge about nutrition and hygiene practices. While most HCWs were sensitive to the barriers of care, other HCWs, including this administrator of a free clinic, are dismissive of these concerns:

> I don't see any obstacles because we don't charge our services, they are free. But the only problem, supplies, that would be the problem we have on our side. For the community, they just have to avail themselves, I don't think there is an obstacle for them […] But when the supplies are there, our services are free. So, I don't see why it could be an obstacle.[28]

In the same statement as saying the clinic has supply issues, this HCW is, in essence, placing the blame of not accessing health services on refugees themselves, which is especially striking given the small number of free clinics available. Quotes like these follow a pattern. HCWs frame poor health being caused by a lack of information and need of awareness among refugee care-seekers. However, at worst, they are blaming refugees for not caring for themselves. We argue that this perspective glosses over the structural constraints refugees face. The following quotes from a medical doctor, a dispensary nurse, and a dispensary clinical officer are instructive of this sentiment:

> Doctor: We normally get hygiene related medical conditions. Mostly they do get infections, UTI [urinary track infection], but we try to advise them on how to wipe themselves where they go to toilets, also to take water in plenty, such things. Another condition is diarrhea. We try to educate them on how to handle food, food hygiene, also how to help anemia— low blood levels. When you tell them to take fruits, they don't like fruits. They don't like green vegetables, liver, they don't like it. Tell them to take liver, they say "yuck"!
>
> Interviewer: Do you think they don't take it seriously because they don't understand the conditions they are in and the extent of the infections?
>
> Doctor: No, actually, they don't understand. Because even if I give you medicine to treat infection, and yet continue with the same practice, the hygiene, you're not changing, you will still get infection. So many cases we get appears to be neglected. They are a lot. The diseases that people have problems with include metabolic diseases and mental illnesses. Both are neglected, and the doctors are not that much interested in talking to the patient about diet. There are not many good doctors who do that. Obesity—which is caused by the diet, diabetes, blood pressure, heart pains—all those can be corrected easily if the people are given good awareness regarding foods.[29]

Here, the doctor states explicitly there is a lack of understanding in practices of nutrition and hygiene by refugees. The informant insists that these major causes of infections and illness "can be corrected easily" through awareness and behavior change, but it does not occur to them the resources that it would require to have adequate living conditions, clean water, and sanitation, or the available income to pay for a diverse diet. Moreover, it is known that UTIs occur at higher rates in pharonically circumcised women (Amin et al., 2013), which suggests a lack of cultural understanding from this HCW. A nurse at a dispensary echoes these sentiments:

> One, because we don't offer services at a cost, we normally support our refugees by giving them free services, as stipulated by the government. This is a dispensary; we don't have any charges. Second, we normally offer them free health talks and health education. We normally also engage with CHVs to sensitize them on good hygiene and nutrition guidance. By the way, there is challenge with refugee communities in terms of nutrition. If you go to a nutrition clinic, most of severe malnourished children, comes from refugees. We normally give them a health talk and health education on how to balance the diet, so that the children can be able to grow. Malnutrition in children is a common problem and we really realize this when we actually ask the combination of foods, they normally offer their children.[30]

27 Male Congolese refugee, Nairobi.

28 Health center administrator, Nairobi.

29 Medical doctor, Nairobi.

30 Nurse, Nairobi.

This nurse identifies anecdotally that a high proportion of malnourished children come from the refugee population in Nairobi. Instead of commenting on the marginalized position, they occupy vis-à-vis Kenyan citizens as a possibility for high prevalence of malnutrition, or difficulties in obtaining food they used to consume in their country of origin, the nurse implies by the education work they do that refugees need to be "sensitized" to good hygiene and nutrition. Putting bluntly, this conveys that refugees should "know better" to avoid malnutrition:

> Refugee children get a lot of pneumonia and a lot of malnutrition; that is a concern. Because it's higher compared to the locals under five, the malnutrition is very high. The other conditions are just respiratory, the GIT [gastrointestinal tract disorders] issues and we also have quite a number of young diabetic refugees, quite a number which is not the same, you notice, it's a bit higher. I also think it's the lack of understanding of how they should treat the children but it's quite high and alarming too from the refugees. For example, on nutrition—which I have said malnutrition is too much. If you find a mother has been educated and put on what to give, but that patient will come as a patient another day because now you are trying to evaluate because you can see the child is malnourished. But when you try to go through the information that was given previously, you can also see what they discussed in the case notes. But what the patient is doing and what she was told, is completely two different things. You find either the concentration, is not mentally stable to handle […] you find that now she will go and do her own things, the child does not improve. Now they will be given something for supplement, for a sick malnourished child, but when they come back the child is not improving. If you try to ask, you will find there is another neighbor, who also had a child like that, and they decided to share. Now you see we are just rotating the same: this one doesn't improve, the other one doesn't come. So, I think the women have a challenge.[31]

The clinical officer makes many of the same individualized points as the doctor and nurse. However, they go even further by pathologizing the lack of malnutrition improvement by suggesting that they are "mentally unstable" rather than unable to materially affect changes due to poverty and marginalization, which is a common outcome of the individualization of public health (Yates-Doerr, 2020). The officer observes it as a problem that two neighbors are sharing supplements for malnourished children, rather than being a larger societal problem of "shared destitution," resulting from widespread poverty and lack of social protection (Omata, 2017).

We cannot make a blank statement that all HCWs blame the lack of knowledge to malnutrition or unhygienic behavior. Indeed, a pharmacist in Kawangware states the contrary opinion plainly: "In my opinion most of the health problems refugees face arise from their environment. In Kenya we all know the refugees live in clustered areas where they cannot get enough provisions and it's hard for them to find clean water. All these bring health issues and ease the spread of communicable diseases like Tuberculosis."[32] On the other hand, there very well may be health education needs in these communities. However, enough healthcare providers expressed these views without any consideration of structural determinants of health to suggest that it is a widely held position among those working closely with refugees in Nairobi, which has implications for how refugees receive care and integration in the city. Moreover, there are enough reports in our data and other research that a non-trivial number of HCWs in Nairobi actively discriminate services to refugees. This suggests that there needs to be an overhaul in the understandings of refugees and health of HCWs more than there needs to be awareness-raising within refugee communities.

Conclusion

We find the terms (dis)integration and (mis)integration to be productive concepts in the highly contested theoretical terrain of refugee and migrant integration. These two concepts display the relational and processual elements of integration at many scales, rather than the individualized and outcome-based views advanced by others. As the definition of (dis)integration sets out, these practices, policies, and discourses attempt to actively discourage inclusion or make them "come apart from society" (Collyer et al., 2020). We observed this at the country and municipal levels in Kenya with spatial segregation through encampment in the peripheries of the country and the enclaving of refugees in poor and informal communities in Nairobi. Moreover, (dis)integration occurs through the exclusionary refugee documentation regime in Nairobi, which severely impedes access to employment and healthcare. (Dis) integration is also apparent at the individual level with constant arrests and harassments of refugees by security forces or discrimination or unsanctioned price inflation at the point of service by healthcare providers. There is a parenthesis in (dis)integration because integration and disintegration are not mere opposites. There are efforts to bridge gaps in care. NGOs and healthcare organizations have interventions for refugees across the country, although these are piecemeal and not sufficient to overcome the interlocking structural oppression of refugees. This holistic view of (dis)integration is held by most refugees we spoke to when they evaluated the primary causes of illness among their population.

Our introduction of the term (mis)integration also aptly analyzes the situation of refugees in Nairobi generally but also zoomed in to the domain of healthcare as well. Like (dis)integration, (mis)integration has the conceptual elasticity to incorporate multiple scales. Refugees in Kenya, and Somalis in particular, have a long history of (mis) integrating. Refugees have defied (dis)integration through encampment for the last 30 years by moving to Nairobi and across the country, integrating in their own ways. The existence in Eastleigh or "Little Mogadishu" densely populated by Somalis is constantly derided by the Kenyan state through security crackdowns, or you will hear ordinary Kenyans talk about the "otherness" of Somalis and Eastleigh with the clear assumption that they are not integrated correctly. When focusing through the lens of healthcare, HCWs are often confounded by practice decisions of Somalis such as the refusal of cesarean births (Lowe, 2019). Our analysis concludes that many Kenyan HCWs have normative understandings for how healthcare integration should take place. They diminish the structural causes of hygiene and malnutrition by perceiving the causes of these issues being poor choices and

31 Clinical officer, Nairobi.

32 Pharmacist, Nairobi.

behaviors—the (mis)integration of individuals. This individualized focus on integration is precisely what this article is critiquing. By focusing on the individual and minimizing systemic oppression, this has key implications in the lives of refugees. These perceptions actively impede progress in reforming the healthcare system in a way to be more inclusive of refugees. Moreover, with HCWs sharing their perceptions of the failings of refugees, this affects the point of service care that refugees receive. Although no HCWs reported doing so, we heard many reports of poor interpersonal treatment or outright denial of service to refugees.

This research has some limitations. This includes interviewing at health clinics, rather than in peoples' homes, which likely biased the sample. Moreover, while we conducted quantitative surveys, this article only used the qualitative data as this is primarily research on experiences and perceptions of displacement and health. Nonetheless, this article brings up numerous important policy implications for refugee healthcare in Nairobi and Kenya. We agree with refugees in the structural nature of refugee (dis)integration, and therefore, change is extremely difficult. As such, most recommendations are "easier said than done." For example, it would be easy to say, yet difficult to make a reality for Kenya to provide more free healthcare services for refugees as it struggles with economic growth and poverty like many other countries in the Global South. With this in mind, we focus on five possible and actionable recommendations based on our analysis, which are by no means "silver bullet" solutions in a society with a long-entrenched history of xenophobia. First, we observe the passage of the Refugee Act 2021 and its accompanying "Marshall plan" as a possible conjunctural moment of change. There is vagueness in the language that should be pressed into to create an inclusive environment in Nairobi, particularly around documentation and right to work. Second, while global aid is highly constrained from the fallout of COVID-19 and the invasion and humanitarian needs of Ukraine, the NHIF should offer subsidies for more than a year, perhaps phasing out support over 5 years. This must be made available to those without proper refugee documentation, as they can often be most vulnerable. Third, we recommend setting up and communicating to refugees reliable complaint systems in clinics and hospitals where refugees can report discrimination in pricing and service in ways that protects whistleblowing. Fourth, while we acknowledge the care available to refugees and asylum-seekers in Nairobi is *ad hoc* and lacking, we recommend a comprehensive mapping (in the appropriate languages) of the health, legal, education, and livelihood resources that these communities are eligible for, and this is widely distributed to refugees and institutions and organizations frequently in contact with these populations. Finally, we observe it as crucial to train and hire refugee HCWs to provide linguistically and culturally appropriate services but also to ensure that the perspectives of health as structural (dis)integration, as elaborated in this article, are shared in healthcare spaces.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The studies involving humans were approved by the University of Edinburgh Research Ethics Committee; Kenya National Commission for Sciences, Technology and Innovation (NACOSTI). The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study.

Author contributions

CB: Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Writing – original draft, Writing – review & editing. BM: Conceptualization, Formal analysis, Investigation, Methodology, Writing – original draft, Writing – review & editing. MW: Data curation, Formal analysis, Investigation, Methodology, Writing – review & editing. PM: Formal analysis, Investigation, Methodology, Writing – review & editing. LA: Investigation, Methodology, Project administration, Supervision, Writing – review & editing.

Funding

The author(s) declare financial support was received for the research, authorship, and/or publication of this article. This project was publicly funded academic research, supported by a grant (reference number ES/T004479/1) from the UK Economic and Social Research Council (ESRC) via the Global Challenges Research Fund (GCRF) Development-based approaches to Protracted Displacement scheme.

Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

The reviewer EM declared a past collaboration with the author PM to the handling editor.

Publisher's note

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