

DETERMINANTS OF PROVISION OF PUBLIC HEALTH CARE SERVICES TO ASYLUM SEEKERS IN NAIROBI CITY COUNTY, KENYA

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ABSTRACT

Globally, up to 59% of asylum seekers live in urban areas as opposed to camps and rural areas. A collaborative strategic plan to provide individuals with quality healthcare that is safe and non-discriminatory irrespective of one's immigration status formulated in 2011 guaranteed asylum seekers access to the publicly provided healthcare facilities as their Kenyan neighbors. The objective of public provision of social services is mainly to deliver social protection to the poor and vulnerable and public officers are faced with the task of providing limited services to a population with varying health needs from different backgrounds and immigration status. This research aimed to establish the determinants of provision of public health care services to asylum seekers in Nairobi City, Kenya. That is, by determining the influence of possession of legal identification documents, official guidelines, and language barriers on the provision of health care services to asylum seekers settled in Dagoretti South Sub-County. The study was guided by the Principal-Agent and Bureaucracy theories. The choice of research design was descriptive research. The targeted population were public officers in the public health facilities in Dagoretti South Sub-County. The study targeted 8 public healthcare facilities with a total population of 148. The census method was used and therefore all the 148 officers were included in the study sample. The data in the current study was from primary and secondary sources. Primary data was obtained using self-directed, semi-structured questionnaires. Quantitative and

qualitative data was obtained using self-directed, semi - structured interviews. Prior to the final analysis, the study carried out a pilot research. Quantitative data was collected and presented in the form of descriptive statistics such as amounts, means/averages, standard deviations, and percentages, among others, while inferential statistics measured the relationship and magnitude between variables. Inferential statistics determined the causation between the predictor and the predicted variable. Qualitative information was dissected utilizing content investigation and the outcomes were presented in themes. The findings indicated that legal identification documents ($\beta=0.288$, $p=0.001$) and official guidelines ($\beta=0.243$, $p=0.003$) had a positive and significant relationship with the provision of healthcare services in Nairobi City County. However, language barriers and the provision of healthcare services in Nairobi City County were negatively and significantly related ($\beta=-0.312$, $p=0.020$). The study concluded that it is critical for asylum seekers to have identification documents to access publicly provided health care services. Therefore, provision of identification documentation should be timely, less tedious, and easy. Similarly, official guidelines were found to enable access to public healthcare services and greater understanding of the same among health workers would positively benefit asylum seekers. The study also established the need for the public health facilities to have official translators or alternative arrangements for translation services, and adequate resourcing of public health facilities.

INTRODUCTION

The large movements of asylum seekers in various areas globally is a fact that cannot be overstated. Conflicts in the Balkans, Middle East, Eastern Europe, South-East Asia, and the Mediterranean coast have continued to produce a steady flow of refugees (Peters & Besley, 2015). Indeed, by end of 2015, UNHCR statistics showed that there were 65.3 million people forcibly displaced worldwide by conflict, war, and persecution and human rights violations. Other causes of displacement have been identified as poor governance, environmental changes, and extreme poverty (Peters & Besley, 2015; Gamlen, 2015).

Public provision of social services such as health, education, water, and sanitation contribute to the wellbeing of individuals, raise productivity, and contribute to the overall quality of life (UNRISD, 2010). Oxfam (2014) and Verbist, et.al (2012) assert that free public health and education services can be used to improve economic inequality. This is especially the case for the citizens in the low-income bracket who largely depend on public provision of basic services due to the absence of a market for these services or poverty. The objectives of public provision of social services are mainly to deliver social protection to the poor and vulnerable, to alleviate poverty and reduce economic inequalities (Afridi, 2017). Implementation of policies and laws and delivery of public services is a preserve of public administrators who form the bulk of government employment and activity (Peters & Pierre, 2003).

It is a fact that public services are often overstretched (UNHCR, 2011) and arrival of large numbers of people into an area puts more pressure on public administrators for more services. Inadequate resources, lack of legal identification documents, and language barriers by asylum seekers pose unique challenges that determine the quality of services provided to asylum seekers by public officers. The IOM (International Organization for Migration) sheds light on the insufficient representation of refugee and minority communities at the negotiating panel to make sure that the interests and concerns of these populations are recognized and addressed from a design perspective. Among the problems discussed are the position of facilities, the availability of adequate amenities, including transport, communications, health care, education, social services, and access to ICT, which are generally overlooked (IOM, 2018).

The report by IOM (2018) on peri-urban settlements in improving and developing nations shows fast urbanization because of both international and internal migration. Thus, living conditions including hygiene conditions can be bad, official, and informal jobs are regularly inaccessible, and the compass of urban organizers tends not to stretch out similarly as the pre-urban settlements, leaving a significant gap in administration. Being at or past the fringe of a city, peri-urban zones can be for all intents and purposes ungoverned, leaving issues unsolved and needs neglected, as well as the settlements being left defenseless against control by composed criminal gangs (Amerasinghe & Marshall, 2017; Shivendra & Ramaraju, 2013). This has elicited problems that have made it impossible for asylum seekers across the globe to not access quality healthcare services.

Kenya has played host to asylum seekers fleeing conflict and war in its neighbouring countries since its independence (Kinyua, 2013). By May 2019, Kenya hosted 476,695 refugees from various countries namely Somalia 259,695, South Sudan 117,472, Democratic Republic of Congo 41,795, Ethiopia 27157, Burundi 13,882, Sudan 10,238, Uganda 2,381, Rwanda 1,735, Eritea 1,725 and others 694. These are resident in the two refugee camps namely Kakuma 190,181, Daadab 211,544 and 74,970 in urban areas (UNHCR, 2019). A plan of action for providing inexpensive, accessible, and transparent healthcare to all individuals, regardless of their immigration status formulated in 2011 guarantees asylum seekers access to the publicly provided healthcare facilities as their Kenyan neighbors (Arnold et al., 2014).

Kenya government implements an encampment policy which limits freedom of movement and choice of residence (Mohamed, 2014). Officially, all asylum seekers, especially those whose claims for international protection have not been determined, should be resident in either Dadaab or Kakuma refugee camps. Early in the history of the two refugee camps, asylum seekers had resided wherever they chose (Campbell et al., 2011). Today, a significant number of asylum seekers live in urban areas including the city of Nairobi (Gitahi, 2015). According to Campbell et al (2011) some of the reasons for this are the need to access higher education, specialized healthcare as well as insecurity in the camps. However, a great majority does not have such leave, and others exist as ‘undocumented’. Other factors that pull them to the urban areas is ‘the hope of a far more diverse socio-economic and cultural community and the inclusion of household members and compatriots who make it easier to join the urban setting.

Generally, as Kiruthu (2014) states, asylum seekers’ life in exile is difficult, regardless of the location of their residence. In Kenya, urban asylum seekers are not entitled to any support from government and the UNHCR therefore they face many hardships including poverty. Hassan (2014) notes that they try surviving on engagement in the informal sector through business, petty trade, remittances, or support by charitable groups, unlike their counterparts in camps who receive material support from UNHCR, although this too is inadequate to meet all their needs (Pavanello, 2010). Xenophobia and criminalization of Somali asylum seekers based on ethnicity and religious affiliation is also common especially due to their perceived association with terrorist activities (Jaji, 2013).

According to Ngao (2018), 59% of asylum seekers around the world live in urban areas and although there are official figures for registered asylum seekers in urban areas in Kenya, the exact size of the asylum seekers’ population in Nairobi is unknown and maybe as high as 100,000 (O’Callaghan & Sturge, 2018). Thus, livelihood problems facing the urban poor affect them regardless of whether they are asylum seekers or not (Aseyo & Ochieng, 2013).

This trend in Southern Asia, Africa and Latin America has been documented extensively, and this increased quantity in empirical literature discusses not only the challenges of migrating to peri-urban areas but also the industrious and evolutive aspects of those communities. The IOM provides a workable example of the Mathare Valley slums in Nairobi on how inhabitants of what is considered an unauthorized and immutable settlements have reacted to

the lack of lawful regulation over settlements by establishing their own socioeconomic and unofficial governance structures (Thorn, Thornton & Helfgott, 2015). This study sought to extrapolate the proof to asylum seekers in Dagoretti South Sub-County given the existence of this area as a pre-urban region.

Robertshaw (2017) did a systematic qualitative review to establish the issues and enablers of health care workers providing primary health care to immigrants in high-income countries. Given its focus on challenges in High income countries, the study falls out of its scope since Kenya is a middle-income country, thus presenting a conceptual gap. Carlson, Jakli and Linos (2018) studied how government-created information vacuums undermine effective crisis management. The study was premised in Greece, however, despite similar conditions that might face refugees in various contexts, the study was narrowed to the role of government-created information vacuums and failed to address the role of other determinants that contribute to the health needs of the refugees and asylum seekers. These among other studies here-in formed the backdrop of the current study to plunge into the depths of research to establish the determinants of provision of public healthcare services to asylum seekers in Dagoretti South Sub-County, Nairobi City County and make a scholarly contribution on the same.

Statement of the problem

There is limited scholarship on studies focusing on determinants of provision and/or availability of health services to asylum seekers in Kenya. Previous studies have focused on different concepts, methods as well as different contexts and thus presenting knowledge gaps in the process. Arnold (2014) aimed to obtain a better view of the challenges that face urban migrants in accessing better health care in Nairobi relative to obstacles faced by the native Kenyans in the same area but did not cover the legal requirements that support or hinder asylum seekers' health access in Nairobi. The current study therefore sought to establish the determinants of provision of public healthcare services to asylum seekers in Dagoretti South Sub-County and make a scholarly contribution to the same.

The study drew insights from the Kenya Health Policy 2014-2030 which proposed to manage upgrades in healthcare services in Kenya in the medium term, in accordance with the 2010 Constitution towards the Vision 2030 and Kenya's international responsibilities. Despite the well stipulated guidelines to ensure equitable healthcare services to everyone including asylum seekers in Kenya, health systems are quite weak, and they do not quite reach the asylum seekers in full effect. Insufficient basic services and overcrowding have worsened an already stressful environment for refugee children (UNICEF, 2017).

Study Objectives

- i. To examine how legal identification documents, determine the provision of public healthcare services to asylum seekers.
- ii. To analyze how official guidelines, determine the provision of public healthcare services to asylum seekers.

- iii. To examine how language barriers, determine the provision of public healthcare services to asylum seekers.

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Access to public healthcare services

Provision of public healthcare services takes various forms in different countries across the world with the aim of assuring health equity for all. Some states use taxation to fund healthcare, others use social and private insurance models while in others, diverse methods are adopted. In the specific case of non-nationals including asylum seekers, the right to access public national healthcare system is usually determined by their legal status (Manby, 2016).

O'Donnell et al (2016) conducted a desk review using routinely available country-level data on 'decreasing the healthcare costs for vulnerable immigrants: the future role of basic care in Europe suggests that the right to accessing the right and quality healthcare services for refugees is constitutionally codified in both the universal and the European Charter to Fundamental Rights. However, the review that targeted the practice in five countries namely Austria, Greece, Ireland, the Netherlands, and the UK shows that national laws and policies in those countries limit this access by use of migration status as a qualification.

In the African continent, according to the Regional Refugee & Resilience Plan (3RP), 2019-2020), Egypt through a ministerial decree in 2012 granted equal access to asylum seekers from Syria to government provided free primary and emergency healthcare services. Consequently, Syrian asylum seekers who tend to reside mostly in urban areas in Egypt have had access to public primary healthcare services at the same cost as the Egyptian population since 2012 (WHO, 2018).

Uganda's Health iSector Integrated Refugee Response Plan 2019-2024 (HSIRRP) guarantees provision of primary healthcare services to asylum seekers in the country. Healthcare service provision to asylum seekers in refugee settlements in Uganda has been until recently delivered through a parallel system comprising of local government facilities and facilities run by Non-Governmental Organizations. Urban asylum seekers accessed government healthcare facilities in the urban areas equally with Ugandan nationals.

Carter (2011) in his pilot study "Access to Maternal & Early Childhood Health Care for Urban Migrants in Eastleigh, Nairobi, Kenya" found that there were gaps on essential data namely epidemiology, health risk and vulnerability and health seeking behaviors from migrants that lead to their marginalization from mainstream healthcare services. The study sought to establish the healthcare experience of women and children in Eastleigh, Nairobi and its findings were that the migrant women faced barriers while seeking to access and use the healthcare services. These barriers were low literacy levels and formal education which hindered decision making about maternal health, language barriers, cost of treatment, cultural and religious beliefs.

An earlier study by Campbell, et al (2011) noted that asylum seekers had access to services provided in the city of Nairobi such as education and healthcare. The study elaborated that previously, the UNHCR provided healthcare services to asylum seekers before eventually establishing a partnership with the then City Council Health Department and GTZ for provision of basic healthcare services.

According to WHO (2011), the National Consultation on Migration Health, coordinated by the Kenyan Ministry of Health, in partnership with IOM and the WHO, devised a strategy to provide available, accessible, cost-effective, and transparent healthcare to all people resident in Kenya. This is in accordance with the first policy objective of the National Health Sector Strategic Plan II, that provides for equitable health care services despite ethnic or racial orientation (Ministry of Health, 2005). This provided a further basis for extending government funded healthcare services to asylum seekers without discrimination.

Possession of legal identification documents and the provision of public health care services to asylum seekers

A precondition to access government provided services is often the production of identification of proof of legal presence in the country as a national, refugee or other regular migrant. The 1951 Convention on the Status of refugees requires states to provide identification documents to refugees such as travel documents or identity papers. According to Manby (2016), lack of legal documentation is the greatest barrier to the safety of people compelled to flee due to war, persecution, or natural disasters. Essentially, an individual without identification papers is unable to travel legally. Identity documents allow ascertaining of age for children and family connections. Those who lack identification papers may face difficulties in demonstrating entitlement to nationality or refugee status. The lack of equal and reliable identification procedures puts displaced people at risk of abuse and exclusion. Access to critical public services would be limited. If registration and identification procedures are not properly carried out, people who qualify to be recognized as asylum seekers may end up being deported (Manby, 2016).

Spahl and Österle (2019) studied the health care access for urban refugees in Turkey and their study noted that Turkey currently hosts more refugees than any other country in the world. Using semi-structured interviews with experts and active participants in healthcare in Ankara, they established that although no formal system is designed for refugee healthcare provision, the Turkish primary public healthcare system allows access only by refugees with valid identity papers. More specifically, an Identity Card is needed for Syrian refugees while a residence permit is mandatory for any healthcare to non-Syrian refugees. However, there does exist a stratification between citizens and non-citizens where private hospitals treat only the Turks on one hand and between the various nationalities of refugees.

According to Alfaro-Velcamp (2017), the South African Immigration Act 2002 requires immigrants in South Africa and providers of medical treatment to verify the legal status of patients prior to actual treatment; meaning valid identification documents must be produced

before services can be rendered. This is despite the provisions of the National Health Act of 1998 and the Refugee Act of 2008 that guarantees refugees the right to access healthcare. Alfaro-Velcamp noted that hospital administrators therefore had to struggle to determine the legal rights accorded to each patient according to the various laws regulating asylum seekers, refugees, migrants, and medical tourists. As a result, doctors and healthcare providers did not have clear knowledge as to who they could treat and to what extent, which invariably led to some not getting the care they needed. More confusion was caused by delays by the Department of Home Affairs in determining appeals by rejected asylum seekers as validity of asylum seekers permits could be easily ascertained.

Arnold et al. (2014) did a research into the accessibility/proximity to urban migrant health care in Nairobi, Kenya and indicated that Kenyan healthcare service providers require identification of some sort for patients to access certain healthcare services in government facilities, to prove legal status in the country and for administrative reasons. This certainly locks out those who are unable to produce identification documents. The study used interviews for government officers and other service providers and focus group discussions with the migrant and national respondents. The government officers in the study were administrative personnel and not hospital employees in direct contact with patients.

Official guidelines and the provision of public healthcare services

The obligation to provide government paid public healthcare services is based on international legal instruments, domestic law, and related policies. State parties to the 1951 United Nations Convention on the Status of Refugees assume the duty to promote the rights including the right to health.

Bauhoff and Goßpffarth (2018) study 'Asylum Seekers in Germany Differ from Regularly Insured in Their Morbidity, Utilizations and Costs of Care' observed that Germany's Constitution coupled with European Union's directives grants asylum seekers access to medical care services in the country. Through analysis of administrative data, the study established that access is limited during the period an asylum seeker is waiting for their claim for protection to be determined. This is accomplished through a three-stage system with initial services being offered at centralized reception centers where new asylum seekers are received. Once the asylum seekers move from here after 6-12 weeks to Municipalities, the latter provides them a limited number of health care services. Full access equivalent to that of German citizens is granted once the application for protection is granted.

The WHO African region (2018) report and MoU (Memorandum of Understanding) signed in Ethiopia by the Federal Health Ministers of the United Nations (FMOH), UNICEF and UNHCR (Agency for Refugees and Return) guarantees all asylum applicants the right to equivalent basic health care services. ARRA implements Primary Health Care services in all 26 refugee camps free of charge for refugees and host communities while refugees are referred to government hospitals for secondary health care at the same cost as nationals.

Kenya, as a signatory to the 1951 Convention, its 1967 optional Protocol as well as the 1969 OAU Convention does allow access to health services to asylum seekers and refugees on its territory. Further, the 2010 Constitution provides for the provision by government the highest attainable standard of health to all. Responsibility for primary public healthcare provision is mainly with County governments which oversee levels 1-5 health facilities while the National government manages level 6 facilities that also serve as teaching hospitals.

Language barriers and the provision of public healthcare services

Language barriers place significant limitations on the interaction between the healthcare providers and patients as accurate diagnosis and subsequent treatment depends on clear understanding of the problems presented by a patient by the doctor or clinician. The quality of services offered is also dependent on effective communication between the patient and the doctor or clinician. The official languages spoken in Kenya are English and Kiswahili, while the asylum seekers in the country originate from countries such as Democratic Republic of Congo, Rwanda, Burundi, and South Sudan where different languages are spoken.

Chuah, et al (2018)'s qualitative study on healthcare requirements and limited access between refugees and asylum-seekers in Malaysia, found that language barriers among health workers and refugees and asylum-seekers resulted in a breakdown in communication and impoverished quality of services. The study also found that the inaccessible translation facilities implied patient knowledge on past medical and family background. The study aimed to define the health criteria and access barrier for refugees and asylum seekers from the perspective of medical suppliers in Malaysia.

In Switzerland, Jaeger et al (2019), sought to examine the communication barriers in pediatric and adult patient healthcare, to portray its ramifications, to uncover how they are overcome, and to underline the use and potential unresolved conflicts of health care professionals. Basic health care providers participated in a countrywide internet survey and the results suggested that immigrants (asylum-seekers and refugees) were most affected, but there were also significant communication issues with other migrant workers. Adult lay translators have been the most frequently used communication strategy in the case of language barriers. Physicians' absence mostly meant that they had to deal with body language and lack of understanding. Professional translators have every now and then been used, but by far not based on specific requirements. The study consequently indicated that there were adverse repercussions due to a lack of professional translators that could have an impact on the quality of care.

Hunter-Adams and Rother (2017) did an investigation of language obstructions between South African human services suppliers and cross-outskirt immigrants investigating the complexity of wellbeing data the executives from the point of view of cross-fringe transients looking for prenatal care in Cape Town, South Africa, to feature the significance of top-notch clinical understanding. Utilizing surveys and focus group discussions with immigrants, members from Zimbabwe found that they could not talk the nearby South African language

(IsiXhosa), which prompted the marking and generalizing of medicinal services experts. The Congolese and Somali respondents mentioned medical procedures, such as tube conjugation, which were carried out without assent. Stakeholders have often attempted to position the responsibility of translator, leading to a loss of revenue and unqualified medical explanation. Respondents raised concerns about undesired protocols or the inability to access medication. These challenges of information exchange without a common language (and without a qualified medical understanding), rather than the direct denial of care by health workers, mediated these meetings.

The findings of IOM (2011) on 'Access to Maternal & Early Childhood Healthcare for Urban Migrants in Eastleigh, Nairobi, Kenya: A Pilot Study' showed language barriers (among others) as contributing to the marginalization of migrants from mainstream health services. Through a cross-sectional survey of 81 participants of Somali origin and Kenyan nationals and 3 key informant interviews the study identified language barrier between the migrants and the Kenyan service providers who spoke English and Kiswahili the national languages, as a major problem and that nothing worked without resolving this, mainly by having a translator. Consequently, some migrants assumed the health providers were rude to them and did not provide services of the quality expected.

By conducting a research on identifying better refugee policies for an evolving crisis, Rook (2020) found that just like Italy, countries like Uganda and Kenya face their unique portion of challenges on dealing with the asylum Seekers. These challenges include the differences in language which necessitate the need for translation. Miscommunication results in misinterpretation of information and thus there is no understanding between the natives and the Asylum Seekers. Therefore, the study recommended the provisions for improved education to refugees in camps through Kiswahili Language Learner (KLL) programs and access to secondary education that does not require refugees seeking movement passes and forfeiting access to aid.

RESEARCH METHODOLOGY

The study applied descriptive research design. Dagoretti South Sub-County was chosen as a study site as is one of the seventeen sub-counties in Nairobi with a significant population of asylum seekers (Pavanelo, Elhawary & Pantuiliano, 2010). Dagoretti South Sub County in Nairobi County is the fourth largest in population size (KNBS, 2019) and covers an area of 25.30 square kilometers (Nairobi County Integrated Development Plan, 2014). It has 5 wards (administrative regions) namely Mutuini, Ngando, Riruta, Uthiru and Waithaka. This area hosts asylum seekers and refugees mainly from Democratic Republic of Congo, Rwanda, Burundi, and South Sudan.

The targeted population were public officers in the health facilities in Dagoretti South Sub-County and 11 key informants who were asylum seekers. According to the Ministry of Health (2018), there are 45 health facilities in Dagoretti South Sub-County out of which 8 are public/government run. Thus, the study targeted all the 8 public healthcare facilities. Through

the census method, the study targeted all 148 public officers (doctors, nurses, laboratory technicians) in the 8 health facilities. The population was distributed as follows:

Table 1: Target population of public officers

Serial No.	Name of the public health facility	Population
1	Mutuini - Sub-District	34
2	Jacaranda Health Center	20
3	Riruta Health Centre	28
4	Waithaka Health Centre	30
5	Dagoretti Corner Health Centre	16
6	Dagoretti Approved School Health Center	4
7	Chandaria Health Centre	11
8	Uthiru/Muthua Dispensary	5
Total		148

Source: *Ministry of Health (2018)*.

The information in the present analysis was primary, where it was collected from 148 public healthcare officials using self-administered semi-structured questionnaires consisting of open-ended questions. These instruments provided qualitative data that helped to collect more evidence regarding individuals (analysis unit) under study. One to ten per cent is regarded as an adequate sample during a pilot research (Mugenda & Mugenda, 2003). The pilot study covered 15 respondents representing 10% of the target population (Kistin & Silverstein, 2015). Pilot study was conducted on 15 (that is 0.1×148) public officers in the public health facilities in the neighboring sub-county that is the Westlands Sub County. These pilot respondents did not participate in the final study.

The information collected from the field was formatted, classified, and organized into themes. The quantitative data was collected and presented in descriptive statistics in form of frequencies, means, standard deviations, median and percentages. Inferential statistics were likewise used to link the independent variables and the dependent variable. Qualitative data was processed manually and analyzed thematically, and the results were presented in prose/thematic form, figures, and tables. The whole analysis was carried out by use of Excel and SPSS software v21.0. To measure the cause and effect between the predictor and the predicted variables, the study used the following: R squared, F statistic, regression coefficients at 0.05 (95 % confidence interval).

DATA ANALYSIS, PRESENTATION, AND INTERPRETATION

A response rate of 89.86% was achieved being 133 correctly filled questionnaires out of the 148 issued. This return is adequate according to Allen (2016) and Rindfuss (2015) who noted that a response rate of above 50% is adequate for a descriptive study. On gender of the Respondents, 97 (72.9%) of the respondents are female while 36 (27.1%) of them are male. On age of the Respondents, over 50% of the respondents, that is 77.4% of them are over 35 years with 39.8% of them being between 40 and 55 years. On the level of education, 64.7% of the respondents have attained a college certification (that is most nurses and clinical officers are mostly diploma and certificate holders) while 30.8% of them have are graduates, an indication of high level of literacy in the health department. This implies that health

employees in public health facilities in Nairobi County are qualified and have long-term expertise for their jobs. In healthcare system, experience, knowledge, and expertise is paramount and thus, it requires the healthcare facilities to recruit highly trained and educated staff for better and quality healthcare services. On the period of working, 64.7% of the respondents in the healthcare facilities have been working in the hospitals for over 10 years.

Possession of legal identification documents and the provision of public healthcare services to asylum seekers.

The study sought to determine how legal identification documents affected the provision of public healthcare services to asylum seekers. Therefore, the findings are related to the descriptive, and inferential statistics as shown.

Although asylum seekers do not need to have identification documents to access services at facilities in levels 1,2 and 3 (dispensaries and health centers), majority of the respondents (86%) agreed that it is very crucial for the asylum seekers to have their identification documents to access healthcare services at levels 4,5, and 6 (County and referral hospitals).

Indeed, UNHCR recommends that asylum seekers should be given identification documents by the relevant national registration authorities. This official recognition of asylum seekers in the adoptive country includes proper recording of births of children and issuance of birth certificates (UNHCR, 2020).

Table 2: Responses related to legal identification documents

Statements	SD		D		N		A		SA		M	Std. D
	F	%	F	%	F	%	F	%	F	%		
Asylum seekers are required to have identification documents before being provided public health services	4	3.0	10	7.5	0	1	6	1	3	.3	2.2	1.1
Possession of multiple identity certificates by asylum seekers pose a challenge to public officers	16	12.0	9	6.8	8	5	0	1	0	.6	2.3	1.3
Possession of outdated identification documents by asylum seekers poses a challenge to public officers	11	8.3	9	6.8	7	3	1	3	5	.3	2.3	1.2
Average											2.3	1.23

SD =Strongly Disagree, D = Disagree, N =Neutral, A =Agree, SA =Strongly Agree, F =Frequencies, % =Percentage distribution, M =Mean and Std. D =Standard Deviation

Source: Research Data (2020)

From Table 2, it was indicated by 79 respondents (59.4%) that asylum seekers are required to have identification documents before being provided public healthcare services. The respondents generally agreed with the statement (M=2.2, SD=1.1). The findings, likewise, revealed that 90 respondents (67.7%) agreed that possession of multiple identity certificates by asylum seekers pose a challenge to public officers. The respondents generally agreed with

the statement ($M=2.3$, $SD=1.4$). In addition, 83 respondents (62.4%) indicated that lack of NHIF subscription by asylum seekers poses a challenge to public officers. The respondents generally agreed with the statement ($M=2.4$, $SD=1.3$).

Majority of the respondents 86 (64.6%) likewise, indicated that possession of outdated identification documents by asylum seekers poses a challenge to public officers. The respondents generally agreed with the statement ($M=2.3$, $SD=1.2$). The results presented a mean score of 2.3 and a standard deviation of 1.23 indicating that the participants were in agreement with the statements in the table. These results agree with Alfaro-Velcamp (2017) who noted that lack of documentation made South African hospital administrators struggle to determine the legal rights accorded to each patient according to the various laws regulating asylum seekers, refugees, migrants, and medical tourists. As a result, doctors and healthcare providers did not have clear knowledge as to who they could treat and to what extent, which invariably led to some not getting the care they needed.

The respondents were likewise asked other ways in which the legal identification documents affected the provision of public health care services to asylum seekers in the health facility. They responded as follows:

Respondent 21: *Some asylum seekers have raised complaints about delay in the issuance of the identification documents as this disqualifies them from registering for the NHIF cover. In this case, when one needs specialized treatment, UNHCR or other agencies supporting asylum seekers must guarantee that the medical bills will be paid, otherwise the asylum seeker will need to meet the bill themselves.*

Respondent 13: *Asylum seekers need to have documents authorizing them to live in Nairobi. If they do not have, then they are charged higher fees for medical services as other non-nationals.*

This is in line with Kenya government's encampment policy which limits freedom of movement and choice of residence (Mohamed, 2014). Officially, all refugees and asylum seekers should be resident in either Dadaab or Kakuma refugee camps, but there are exceptions where some can live in urban areas and the reasons for this are the need to access higher education, specialized healthcare as well as insecurity in the camps (Campbell et al, 2011). The results also support the argument advanced by the bureaucracy theory that the choices and activities of public service bureaucrats, really 'become', or speak to, the arrangements of the public offices they work for. This is on the grounds that an individual regularly and legitimately encounters policy as the choice that the public officer makes about their specific case. Strategy turns into the advantage that the public officer gives them access to, or the approval that public officer grants them. Public officers along these lines can 'make policy' since they can practice prudence (settle on a decision about how they will practice their capacity).

This implies that healthcare officials change policies in various ways to meet customers' needs. One way is by allowing UNHCR and other agencies to meet the bills of asylum seekers who do not have the necessary documents such as NHIF. Secondly, the asylum seekers can access the services at a higher fee, as other foreigners, thereby not benefiting from subsidized services as they would ordinarily be entitled to as asylum seekers.

The findings in table 2 agree with respondents from asylum seekers’ communities in Dagoretti South. These were some of their responses:

Respondent 59: *Asylum seekers are not required to produce identification to access basic healthcare services provided in levels 1,2,3 which include community health facilities, dispensaries, and health centers. However, in County and referral hospitals in level 4,5 and 6 identification documents are required.*

Respondent 46: *Legal documentation is important as UNHCR and other agencies only assist those who need services that are unavailable in levels 1,2, and 3 facilities on the condition that they have authorization to live in Nairobi. Legal documentation indicates where an individual is authorized to live.*

Correlation between legal identification documents and provision of public healthcare services

Table 3: Correlation between legal identification documents and provision of public healthcare services

Correlations		Healthcare services provision	Legal identification documents
Healthcare services provision	Pearson Correlation	1	
	Sig. (2-tailed)		
	N	133	
Legal identification documents	Pearson Correlation	.532**	1
	Sig. (2-tailed)	0.001	
	N	133	133

** Correlation is significant at the 0.01 level (2-tailed).

Source: Research Data (2020)

The findings in the table above show that there is a positive and significant association between legal identification documents and provision of healthcare services ($r=0.532^{**}$, $p=0.001$). The r values of 0.540 indicate absolute value of greater than 0 which indicates that legal identification documents have a linear relationship with provision of healthcare services. This implies that an increase in aspects related to legal identification documents results to an increase in the provision of healthcare services. These findings concur with Spahl and Österle (2019) who established that although no formal system is designed for refugee healthcare provision, the Turkish primary public healthcare system allowed access only by refugees with valid identity papers. More specifically, an identity card was needed for Syrian refugees while a residence permit was mandatory for any healthcare services to non-Syrian refugees.

Regression Analysis for legal identification documents

Table 4: Model of Fitness

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.532a	0.283	0.278	0.3732

a Dependent Variable: provision of healthcare services

b Predictors: (Constant), Legal identification documents

Source: Research Data (2020)

The results in the table above, presents the fitness of regression used in explaining the study phenomena. Aspects related to legal identification documents are an essential explanatory

variable in the provision of public healthcare services in Nairobi City County. This is evident, as shown by the R square value which 0.283. This implies legal identification documents explain 28.3% of the outcome in provision of public healthcare services.

Table 5: ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	7.216	1	7.216	51.823	.000b
	Residual	18.241	131	0.139		
	Total	25.457	132			

a Dependent Variable: provision of healthcare services

b Predictors: (Constant), legal identification documents

Source: Research Data (2020)

The table above provided on the analysis on variance (ANOVA). The results show that the model was statistically significant. The table also shows that legal identification documents significantly influence the provision of public healthcare services in Nairobi City County. This is further supported by the F statistic 51.823 where the value was greater than the critical value at 0.05 significance level, $F_{\text{statistic}} = 51.823 > F_{\text{critical}} = 3.86 (1,131)$.

Table 6: Regression of coefficients

Variable	β	Std. Error	t	Sig.
(Constant)	2.024	0.265	7.648	0.000
Legal identification documents	0.507	0.070	7.199	0.000

a Dependent Variable: provision of healthcare services

Source: Research Data (2020)

Regression of the coefficients results in the table above, revealed that legal identification documents and provision of public healthcare services are positively and significantly related ($\beta=0.507, p=0.000$). This implies that improvement in 1 unit of the aspects related to legal identification documents improves the provision of public healthcare services by 0.507 units (vice versa is also true).

Official guidelines and the provision of public health care services to asylum seekers

The study sought to determine how official guidelines affect the provision of public healthcare services to asylum seekers. Therefore, the findings are related to the descriptive, and inferential statistics as shown.

Descriptive Results on official guidelines

Table 7: Awareness of Kenya's Health Policy on asylum seekers

Category	Frequency	Percentage (%)
No	6	4.5
Yes	127	95.5
Total	133	100

Source: Research Data (2020)

The findings from the table above indicate that most of the respondents from the study (95.5%) agreed that they are aware of the Kenya's Health Policy on asylum seekers. This was justified by the training

and education the public healthcare officials have undergone in the training institutions and the guidelines provided by the UNHCR.

Table 8: Responses related to official guidelines

Statements	SD		D		N		A		SA		M	St d. D		
	F	%	F	%	F	%	F	%	F	%				
Asylum Law and Policy allow asylum seekers access healthcare services without discrimination	7	5.3	8	6.0	2	16.	4	36.	9	8	47	35.3	3.9	1.1
Public officers would benefit from guidelines on handling unique healthcare needs presented by asylum seekers	4	3.0	9	6.8	0	6	2	1	38	28.6	3.8	1.0		
Kenya’s Health Policy offers free and quality health care to both nationals and asylum seekers	9	6.8	0	7.5	3	27.	4	34.	6	6	32	24.1	3.6	1.1
Asylum Law and Policy provides asylum seekers in with public health insurance services without prejudice	5	3.8	2	19.	2	21.	4	35.	7	3	27	20.3	3.5	1.1
Average												3.7	1.1	

SD =Strongly Disagree, D = Disagree, N =Neutral, A =Agree, SA =Strongly Agree, F =Frequencies, % =Percentage distribution, M =Mean and Std. D =Standard Deviation

Source: Research Data (2020)

The results in Table 4.13 revealed that majority of the respondents 96 (72.1%) agreed with the statement that asylum law and policy allow asylum seekers access public healthcare services without discrimination. The responses had a mean of 3.9 and a standard deviation of 1.1. Majority of the respondents 90 (67.7%) agreed with the statement that public officers would benefit from guidelines on handling unique healthcare needs presented by asylum seekers. The responses gave a mean of 3.8 and a standard deviation of 1.0. Furthermore, majority of the respondents 90 (67.7%) agreed with the statement that Kenya’s Health Policy offers equitable public health care services to both nationals and asylum seekers. The responses showed a mean of 3.9 and a standard deviation of 1.2.

In addition, majority of the respondents 78 (58.7%) agreed with the statement that Kenya’s Health Policy offers free and quality public health care to both nationals and asylum seekers. The responses gave a mean of 3.6 and a standard deviation of 1.1. The results also showed that 74 (55.6%) agreed with the statement that asylum law and policy provide asylum seekers in with public health insurance services without prejudice. The responses had a mean of 3.5 and a standard deviation of 1.5. The results presented a mean score of 3.7 and a standard deviation of 1.1 indicating that the participants were in agreement with the statements in the table.

These findings match the bureaucracy theory argument that the most efficient way that human activity can be organized is through hierarchies commonly known as bureaucracy. Bureaucracy consists of three principles: tiered supervision, labour specialization and prescribed rules (Marx, 1970). According to Suphanchaimat, Kantamaturapoj, Putthasri and Prakongsai (2015), workplace service

delivery standards and guidelines need to be consistent to assure, or at least suit, the needs of migrant patients.

The respondents were likewise asked to indicate what other ways had the official guidelines affected the provision of public health care services to asylum seekers. These were some of their responses:

Respondent 72: *The guidelines have helped us to offer health services to asylum seekers as a fulfillment of their right to health. All human beings have health needs, and it is important that asylum seekers benefit from our health services.*

The findings in table 4.12 and table 4.13 agree with respondents from asylum seekers' communities in Dagoretti South. These were some of their responses

:

Respondent 88: *Asylum seekers can access health services as Kenyan nationals. However, indirect discrimination exists where some health workers tell the asylum seekers to go get assistance elsewhere or are rude to them unnecessarily. Drugs and other items are sometimes withheld from asylum seekers, but Kenyans are given.*

Respondent 115: *Besides NHIF cover, Linda Mama is additional product for expectant mothers and is meant to cover all child delivery costs. Apparently, asylum seekers are not allowed to use this product despite having registered for it.*

These results indicate a goal conflict as postulated by the principal-agent theory, which is used to analyse the relationships between the principals (policymakers) and agents (the public officers). The theory developed in the 1970s by Michael Jensen and William Meckling prescribes a goal conflict between the principal and the agent. The goal conflict is clarified by Collin et al (2018) who, citing Lipsky, acknowledged difficulties confronting the public health care workers to be the desire to meet the needs of patients which maintaining efficiency and effectiveness, inadequacy of resources in the face of growing patient needs, and lack of motivation due to pressure to maintain a delicate balance between patient needs and the goals of their employer.

Correlation between official guidelines and provision of public healthcare services

Table 9: Correlation between official guidelines and provision of public healthcare services

Correlations		Healthcare services provision	Official guidelines
Healthcare services provision	Pearson Correlation	1	
	Sig. (2-tailed)		
	N	133	
Official guidelines	Pearson Correlation	.550**	1
	Sig. (2-tailed)	0.001	
	N	133	133

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Source: Research Data (2020)

The findings also show that there is a positive and significant association between official guidelines and provision of public healthcare services ($r=0.550^{**}$, $p=0.001$). The r values of 0.550 indicate an absolute value of greater than 0 which indicates that official guidelines have a linear relationship with provision of public healthcare services. This implies that an increase in aspects related to official guidelines, results to an increase in the provision of public healthcare services. According to World Health Organization (2020), the organization recommends free health care services in all 26 refugee

camps free of charge for asylum seekers and host communities while asylum seekers are referred to government hospitals for secondary healthcare at the same cost as nationals. This promotes their access to healthcare services. Paradise and Sadavarte (2016) likewise, emphasize on the need for readily available and structured guidelines on the healthcare environment, structure, and access to treatment for outsiders for the asylum seekers in addition to the citizens, to access the services.

Regression Analysis for Official guidelines

Table 10: Model of Fitness

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.550a	0.303	0.298	0.3681

a Dependent Variable: provision of healthcare services

b Predictors: (Constant), official guidelines

Source: Research Data (2020)

The results in the table above, presents the fitness of regression used in explaining the study phenomena. Aspects related to official guidelines are an essential explanatory variable in the provision of public healthcare services in Nairobi City County. This is evident, as shown by the R square value which 0.303. This implies official guidelines explain 30.3% of the outcome in provision of public healthcare services.

Table 11: ANOVA

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	7.711	1	7.711	56.918	.000b
	Residual	17.746	131	0.135		
	Total	25.457	132			

a Dependent Variable: provision of healthcare services

b Predictors: (Constant), official guidelines

Source: Research Data (2020)

The table above provided on the analysis on variance (ANOVA). The results show that the model was statistically significant. The table also shows that official guidelines significantly influence the provision of public healthcare services in Nairobi City County. This is further supported by the F statistic 56.918 where the value was greater than the critical value at 0.05 significance level, F statistic = 56.918 > F critical = 3.86 (1,131).

Table 12: Regression of coefficients

Variable	β	Std. Error	t	Sig.
(Constant)	2.142	0.237	9.027	0.000
Official guidelines	0.474	0.063	7.544	0.000

a Dependent Variable: provision of healthcare services

Source: Research Data (2020)

Regression of the coefficients results in the table above, revealed that official guidelines and provision of public healthcare services are positively and significantly related ($\beta=0.474$, $p=0.000$). This implies that improvement in 1 unit of the aspects related to official guidelines improves the provision of public healthcare services by 0.474 units (vice versa is also true). Paradise and Sadavarte (2016) place emphasis on the need for readily available and structured guidelines on the healthcare environment,

structure, and access to treatment for outsiders for the asylum seekers apart from the citizens, to access the services.

Language barriers and the provision of public health care services to asylum seekers.

The study sought to determine how language barriers influenced the provision of public healthcare services to asylum seekers in Dagoretti South, who are mainly from the Democratic Republic of Congo, Rwanda, Burundi, and South Sudan where they speak other languages other than English and Kiswahili as Kenyans. The findings are related to the descriptive, and inferential statistics as shown.

Descriptive Results on language barriers

Table 13: Asylum seekers' problems in communicating with public officers

Category	Frequency	Percentage (%)
No	49	36.8
Yes	84	63.2
Total	133	100

Source: Research Data (2020)

The findings in the table 4.18 indicate that 84 (63.2%) respondents concurred that the asylum seekers experience problems in communication with their doctors, nurses, laboratory technologists among other healthcare workers.

Respondent 64: *The asylum seekers speak different languages from English and Kiswahili. This poses a difficulty for example in case I need to attend to a mother who has a malnourished child because I do not know the name in the asylum seeker's language, of the various foods that the child might need. Translation from English and Kiswahili to Kinyarwanda, Kirundi, French or Arabic as the case may require, would be especially useful for such situations.*

Respondent 29: *Sometimes, an asylum seeker must use sign language to describe their illness and that may not communicate effectively. This is because they are from countries such as the Democratic Republic of Congo, Rwanda, Burundi, and South Sudan where they do not speak English and Kiswahili, and the individuals may not have learnt enough English or Kiswahili to communicate well or they may be new arrivals in the country.*

The study established a common theme in addressing the problems identified; that is the public health facilities are either required to recruit diverse staff who can speak different languages or hire translators. Indeed, the researcher found that some non-governmental organizations have stepped in to address this problem by supporting some health facilities with translators. This is consistent with Jaeger et al (2019) who states that adult lay translators have been the most frequently used communication strategy in the case of language barriers. Lack of translators mostly meant that hospital staff had to deal with body language and lack of understanding. The study consequently indicated that there were adverse repercussions due to lack of professional translators that could have an impact on the quality of care.

Table 14: Responses related to language barriers

Statements	SD		D		N		A		SA		M	Std. D
	F	%	F	%	F	%	F	%	F	%		
Poor interpersonal relationships between the public officers and the asylum seekers impacts negatively on the delivery of services by public officers	2	1.5	4	10.5	34	25.6	9	36.4	4	25.6	2.3	1.0
Lack of a common language prevents communication conveyance between public officers and asylum seekers	2	1.5	1	8.3	24	18.0	0	34.0	5	37.0	2.0	1.0
Information is easily distorted while being translated making it easier for a common understanding.	5	3.8	6	4.5	23	17.3	3	25.6	6	48.0	1.9	1.1
The public officers are unable to get past health history of asylum seekers given the communication hiccups	3	2.3	6	4.5	46	34.6	8	28.6	4	30.0	2.2	1.0
Average											2.1	1.0

SD =Strongly Disagree, D = Disagree, N =Neutral, A =Agree, SA =Strongly Agree, F =Frequencies, % =Percentage distribution, M =Mean and Std. D =Standard Deviation

Source: Research Data (2020)

From Table 4.19, 83 respondents (62.4%) indicated that poor interpersonal relationships between the public officers and the asylum seekers impacts negatively on the delivery of services by public officers. The respondents generally agreed with the statement (M=2.3, SD=1.0). The table, likewise, revealed that 96 respondents (72.2%) indicated that lack of a common language prevents communication between public officers and asylum seekers. The responses generally presented a mean of 2.0 and a standard deviation of 1.0. In addition, 99 respondents (74.5%) indicated that information is easily distorted while being translated making it harder for a common understanding. The results presented a mean score of 1.9 and a standard deviation of 1.1 indicating that the participants were in disagreement with the statements in the table.

Majority of the respondents 78 (58.7%) indicated that the public officers are not able to get past health history of asylum seekers given the communication hiccups. The responses generally presented a mean of 2.2 and a standard deviation of 1.0. On an average, the responses presented a mean of 3.9 which means that a majority of the respondents agreed with the statements; however, the answers were varied as is shown by a standard deviation of 1.0. These findings agree with Hunter-Adams and Rother (2017) who noted that even immigrants, from Zimbabwe could not communicate with the residents in South African language (IsiXhosa). The Congolese and Somali respondents mentioned medical procedures, such as tubal ligation, which were carried out without assent. Respondents raised concerns about undesired protocols or the inability to access medication due to language barriers.

The findings in table 4.18 and table 4.19 agree with respondents from asylum seekers' communities in Dagoretti South. These were some of their responses:

Respondent 93: *The common problem is inability to get an accurate diagnosis. The solution is usually to get a translator to accompany the asylum seeker to the health facility. A lot of them usually carry a family member or a fellow asylum seeker. Sometimes, translation had been done over the phone where the health-worker agrees.*

Respondent 67: *Non-governmental organizations have stepped in to support some health facilities with translators who are also asylum seekers at no cost to the hospitals. These are UNHCR, the National Council of Churches of Kenya (NCCCK) and RefugePoint.*

The necessity of translation was well captured by Kritzinger (2011). In his study on deaf peoples' access to medical services in Worcester in South Africa, he noted that as a minority linguist group, the deaf faced had a limitation of the spoken and written word. He stated that this limitation was evident in the inability to express oneself correctly with the consequence that the clinician was professionally unable to make a correct diagnosis and provide relevant information. Applying this concept to asylum seekers, it can be concluded that they are essentially, a minority linguist group, and even for those who may speak some English and Kiswahili, their written and spoken language is still severely limited and therefore chances of not getting a correct diagnosis are high.

Kubende (2016) research on communication obstacles between student nurses and older patients in Chogoria, Kenya found that communication between nurses and patients is a critical element of satisfactory services. Lack of understanding of a patient's language therefore resulted in poor services which did not meet the needs of the patients. The study therefore recommended that nurses needed to have multiple language competence to have effective communication.

Correlation between language barriers and provision of public healthcare services

Table 15: Correlation between language barriers and provision of public healthcare services

Correlations		Healthcare services provision	Language barrier
Healthcare services provision	Pearson Correlation	1	
	Sig. (2-tailed)		
	N	133	
Language barrier	Pearson Correlation	-.604**	1
	Sig. (2-tailed)	0.000	
	N	133	133

** Correlation is significant at the 0.01 level (2-tailed).

Source: Research Data (2020)

From the table above, there is a negative and significant association between language barriers and provision of public healthcare services ($r = -0.604^{**}$, $p = 0.000$). The r value of -0.604 indicate absolute values of greater than 0 which indicates that language barriers had a linear relationship with provision of public healthcare services. This implies that an increase in aspects related to language barriers, results to a decrease in the provision of public healthcare services. These findings are consistent with Chuah, et al (2018)'s study in Malaysia which found that language barriers among health workers and refugees and asylum-seekers resulted in a breakdown in communication and impoverished quality of services. Likewise, in Switzerland, Jaeger et al (2019) suggested that immigrants (asylum-seekers and refugees) were most affected by language barriers during provision of public health care services, but there were also significant communication issues with other migrant workers.

The results describe the goal conflict as postulated by the Principal-Agent theory especially the conflict between the expectations of the principal, Nairobi City County as the employer, and agents namely the healthcare workers, meeting the needs of clients (asylum seekers) while operating in an efficient and effective manner, and ongoing lack of resources as client needs increase in proportion to agents' increasing resources.

Regression Analysis for Language barriers

Table 16: Model of Fitness

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.604a	0.365	0.360	0.3514

a Dependent Variable: provision of healthcare services

b Predictors: (Constant), language barriers

Source: Research Data (2020)

The results in the table above, presents the fitness of regression used in explaining the study phenomena. Language barrier is an essential explanatory variable in the provision of public healthcare services in Nairobi City County. This is evident, as shown by the R square value which 0.365. This implies language barrier explains 36.5% of the outcome in provision of healthcare services.

Table 17: ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	9.282	1	9.282	75.174	.000b
	Residual	16.175	131	0.123		
	Total	25.457	132			

a Dependent Variable: provision of healthcare services

b Predictors: (Constant), language barriers

Source: Research Data (2020)

The table above provided on the analysis on variance (ANOVA). The results show that the model was statistically significant. The table also shows that language barriers significantly influence the provision of public healthcare services in Nairobi City County. This is further supported by the F statistic 75.174 where the value was greater than the critical value at 0.05 significance level, F statistic = 75.174 > F critical = 3.86 (1,131).

Table 18: Regression of coefficients

Variable	β	Std. Error	t	Sig.
(Constant)	4.972	0.126	39.588	0.000
Language barriers	-0.505	0.058	-8.670	0.000

a Dependent Variable: provision of healthcare services

Source: Research Data (2020)

Regression of the coefficients results in the table above, revealed that language barriers and provision of public healthcare services are positively and significantly related ($\beta=-0.505$, $p=0.000$). This implies that improvement in 1 unit of the aspects related to language barriers reduces the provision of public healthcare services by 0.505 units (vice versa is also true). The findings agree with Chuah et al (2018) who stated that the major challenges to accessing medical care are related to limited

healthcare literacy and insufficient knowledge of one's right to healthcare; language and cultural barriers; security problems arising from a loss of legal status; and failure to afford healthcare due to poor livelihoods. It also stated that bridging language and cultural differences by translation assistance and intercultural preference meant something to asylum seekers and health care providers.

Provision of public healthcare services

Table 19: Responses related to provision of public healthcare services.

Statements	Categories	Freq uenc y	Perce ntage (%)
Is your medical institution able to handle all the asylum seeker patients that visit your centre for medical attention?	Not able at all	47	35.3
	Able all the time	86	64.7
	Total	133	100
According to your centre’s statistics what is the proportion number of asylum seekers patients seeking medical attention against that of nationals?	Less than nationals	102	76.7
	Equal to nationals	20	15.0
	More than nationals	11	8.3
	Total	133	100

Source: Research Data (2020)

From the table above 86 (64.7%) respondents indicated that their medical institutions were able to handle all the asylum seeker patients that visited their centers for medical attention. Likewise, 102 (76.7%) indicated that the the proportional number of asylum seekers patients seeking medical attention was less than that of the nationals. These findings responses are shown in Table 4.25 below:

Table 20: Responses related to provision of healthcare services

Statements	SD		D		N		A		SA		M	Std. D
	F	%	F	%	F	%	F	%	F	%		
Asylum seekers can access all services available in your facility without limitation	1	0.8	14	10.5	23	17.3	49	36.8	46	34.6	3.9	1.0
The healthcare services of available are suitable to the asylum seekers’ needs	1	0.8	5	3.8	26	19.5	52	39.1	49	36.8	4.1	0.9
The public officers (doctors, nurses, laboratory technologists) are able to serve the asylum seekers satisfactorily	2	1.5	5	3.8	22	16.5	55	41.4	49	36.8	4.1	0.9
Average											4.0	0.9

SD =Strongly Disagree, D = Disagree, N =Neutral, A =Agree, SA =Strongly Agree, F =Frequencies a, % =Percentage distribution, M =Mean and Std. D =Standard Deviation

Source: Research Data (2020)

The results in Table 4.25 majority of the respondents 95 (71.4%) agreed that asylum seekers could access all services available in their facilities without limitation. The responses gave a mean of 3.9

and a standard deviation of 1.0. In addition, majority of the respondents 101 (75.9%) agreed that the healthcare services available were suitable to the asylum seekers' needs. The responses gave a mean of 4.1 and a standard deviation of 0.9. Likewise, 104 (78.2%) agreed that the public officers (doctors, nurses, laboratory technologists) were able to serve the asylum seekers satisfactorily. The responses had a mean of 4.1 and a standard deviation of 0.9. The results presented a mean score of 4.0 and a standard deviation of 0.9 indicating that the participants were in agreement with the statements in the table.

The findings in table 4.10 and table 4.11 varied with respondents from asylum seekers' communities in Dagoretti South. These were some of their responses:

Respondent 41: *Drugs are usually in short supply, and asylum seekers are usually sent away with prescriptions and must buy the drugs themselves. Hospitals only have painkillers. For this reason, National Council of Churches in Kenya (NCCK) and RefugePoint run programmes that provide drugs to those asylum seekers who get prescriptions and are unable to buy the drugs. Asylum seekers living in low-income areas of Dagoretti are as poor and vulnerable as nationals living in the same areas so they may not have the money to buy drugs.*

These findings agree with the bureaucracy theory, which postulates that choices, and activities of public service bureaucrats, really 'become', or speak to, the arrangements of the public offices they work for. This is on the grounds that an individual regularly and legitimately encounters policy as the choice that the public officer makes about their specific case. Strategy turns into the advantage that the public officer gives them access to, or the approval that public officer grants them. Public officers along these lines can 'make policy' since they can practice prudence (settle on a decision about how they will practice their capacity).

This implies that healthcare officials change policies to meet customers' needs. Within Lipsky's theory, employees of government services are seen to struggle to meet customer requirements because such requests are unlimited. Lipsky points out that the people who work in the 'weak ends' of the government are also accountable for how they operate (Lipsky, 2010).

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Based on the findings above the study concluded that possession of legal identification documents, existence of official guidelines, language barriers have significant influence on the provision of public healthcare services. The findings revealed that possession of legal documents had the most influence on the provision of healthcare services to asylum seekers, followed by official guidelines. Language barriers had a negative influence and therefore contributed the least to the provision of healthcare services to asylum seekers.

Recommendations

The study recommends the following:

- i. Public health facilities should either recruit staff who can speak various languages or hire translators.
- ii. The Government of Kenya should scale up processing of identification documents to ensure that the asylum seekers can access public healthcare services without fear of rejection or apprehension.

- iii. The ministry of Health needs to ensure that adequate resources are allocated to all health facilities to avoid having patients buying drugs from private pharmacies.
- iv. Prejudice and discrimination should be avoided in the delivery of services to asylum seekers. Upon presentation of a valid identification card, the asylum seeker should be provided with equitable, and timely healthcare services.

Areas for Further Studies

The current study sought to investigate the determinants of provision of public health care services to asylum seekers in Nairobi City County, Kenya. Given that the study narrowed its focus on Nairobi City County, an extrapolation could be done on other neighbouring counties for the purposes of comparison. This would expound on the scope of the study and enable the generalization of findings and ultimately be able to fill some knowledge gaps as the contextual gap in the entire Kenya.

In addition, to expand the current study, other intervening factors or variables such as the policies by UNHCR could be incorporated in the research to establish how the study variables are affected by such other factors.

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