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RELEVANCE OF CASH TRANSFER PROGRAMME ON ACCESS TO QUALITY HEALTHCARE AMONG REFUGEES IN KAKUMA CAMP, KENYA

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Abstract: *Cash transfers may have direct and indirect impact on health status of refugees in camps. The cash transfer programme in Kakuma camp was intended to help refugees realize improved social welfare but experience indicates that refugees continue to face a backlash when it comes to social development dimensions including access to quality healthcare. Therefore, this study sought to establish the impact of cash transfer programme on access to quality healthcare among refugees in Kakuma camp. Social systems theory, resilience theory and social development model guided the study. A convergent parallel mixed method design was adopted. The sample size was 400 comprising of 370 refugees selected using simple random, 5 key informants and 25 refugee community leaders selected purposively. Questionnaires, interviews and FGDs were used. SPSS analysed quantitative data while thematic analysis was for qualitative data. Tables, graphs, charts and verbatives were employed. Findings revealed that there was a significant relationship between cash transfer and access to quality healthcare among refugees in Kakuma camp (P- = 0.133>0.05). The study concluded that cash transfer has not had much contribution on improving access to quality healthcare among refugees in Kakuma camp. The impact of cash transfer was too little because it mostly related to the transportation to health facilities. These findings had professional implications to social policy and welfare social work practice as its focus was premised on the wellbeing among refugees. The study recommends that UNHCR and its partners and GoK should strategize to include the component of healthcare in the cash transfer programme by providing supplementary funding to households to cater for healthcare. Subsequently, health insurance covers for refugees should be integrated in the cash transfer programme to facilitate specialized healthcare outside Kakuma camp and aid refugees suffering from terminal diseases like cancer which need extensive resources for treatment.*

Key words: *Cash transfer, Camp, Quality healthcare, Refugees*

1.1 Background to the Study

The issue of refugees is a global concern. UNHCR estimated that, by the end of the year 2020, the number of refugees globally was over 26.4 million of which eighty-four percent were hosted by developing countries including Kenya (UNHCR, 2020). Refugees in camps worldwide face social development concerns which calls for social welfare attention. In most encampment situations like in

Kakuma camp, refugees are legally prohibited from social mobility and welfare through employment or setting roots outside the camps. As a result, many refugee settlements become permanent densely populated urban 'encampment' spaces often characterized by violence, stasis, lethargy, and despair (Vemuru et al., 2020). The cash transfer program in Kenya, was initiated in 2015 in recognition of the commercial economy and established markets in both Kakuma and Dadaab refugee camps. In 2019 the cash transfer was improved to cover other refugees' welfare needs including health (UNHCR, 2020). Oka et al., (2019) observed that the two main systems that have been developed by UNHCR to deliver aid to refugees are (a) cash-transfers that enable refugees to access cash for purchasing goods or services, and (b) non-transferable vouchers that can be used under certain conditions or restrictions in selected shops for purchasing food, non-food items, and other services like health. World Food Programme (2020) affirm that most refugees utilized the cash given to invest in food security, health, education and/or business or employment opportunities. However, there were some challenges associated with the cash transfers.

1.2 Statement of the Problem

The introduction of cash transfer programme among refugees was sort to be a liberation and mechanism to cushion refugees from adversities that camp life causes. Research conducted on the economic and social effects of cash transfers for refugees in Jordan revealed that cash transfer programme in refugee camps has the ability to enable refugees reduce reliance on negative coping strategy thereby realizing social development hence improved access to healthcare (Hagen-Zanker et al., 2017). However, this has remained a dream in the eyes of many refugees not only in the Kenyan refugee camps but across the globe.

The cash transfer programme in Kakuma refugee camp was intended to help refugees realize improved social welfare but experience indicates that refugees continue to face a backlash when it comes to social development dimensions including access to quality healthcare. Evidence continues to unfold the existence of certain challenges in realizing access to quality healthcare. This inadequacy is attributed to the fact that cash transfer assistance tends to be predominantly short time with little potential to facilitate social well-being and improve refugees' access to quality healthcare in the long term. The transfer of approximately 14 USD per person per month limits refugees' access to quality healthcare. This stems from the notion that the cash transfer income may be insufficient to facilitate economic stability and eventually help refugees attain human dignity and self-esteem as emphasized by social work values. It is imperative to note that cash transfer programme may have made some concerted effort to promote human well-being but there is more need to establish the impact of cash transfer programme on access to quality healthcare among refugees in Kakuma camp.

1.3 Research Objective

To establish the impact of cash transfer programme on access to quality healthcare among refugees in Kakuma camp

1.4 Research Questions

How has the cash transfer programme influenced access to quality healthcare among refugees in Kakuma camp?

1.5 Conceptual Framework

The independent variable was cash transfer programme within Kakuma refugee camp in Kenya. The dependent variable was access to quality healthcare which was measured by improved social functioning and welfare. These parameters aided in establishing how the cash transfer programme contributed to access to quality healthcare among refugees in Kakuma camp. The intervening variables were; Government of Kenya laws and policies, UNHCR agencies' policies and scope, social environment and cultural factors.
This is illustrated in figure 1.

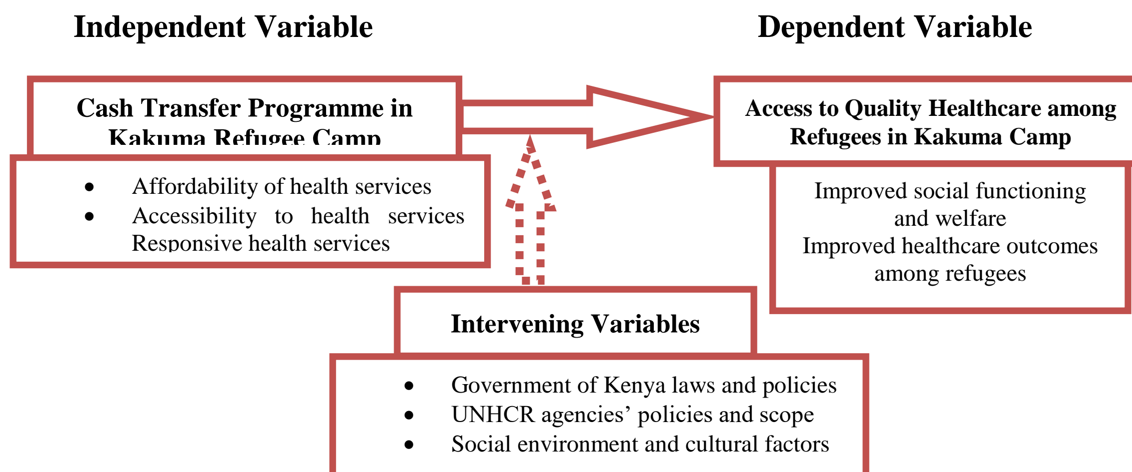

Figure 1: *Conceptual framework showing the relationship between cash transfer programmes and Access to Quality Healthcare in Kakuma refugee camp*
Source: *Own Conceptualization, 2021*

1.6 Literature Review and Theoretical Framework

Healthcare among refugees and Cash transfer programme

Healthcare is one of the fundamental aspects of human wellbeing. By virtue of refugees being human beings, they are entitled to quality healthcare despite their status. In May 2017, the World Health Assembly endorsed resolution 70.15 on promoting the health of refugees and migrants (3). This resolution urge Member States to consider providing the necessary health-related assistance through bilateral and international cooperation to those countries hosting and receiving large populations of refugees and migrants, as well as using the Framework of priorities and guiding principles at all levels (Ortiz-Echevarria et al., 2019).

Quality healthcare can be accessed by refugees in camps if cash assistance is provided to refugee households so as to cover the direct and indirect costs of healthcare. Healthcare direct costs include costs related to healthcare fees and medication such as consultation fees, diagnostic tests and cost-share for hospitalization. While indirect costs include the incurred costs of transportation to healthcare facilities (World Health Organization, 2020). On the same note NRC, (2018b) observed that 60% of Syrians refugees with chronic conditions were not able to access medicines and healthcare as a consequence of their refugee status. Although Jacobsen and Fratzke, (2020) indicate that cash transfer in refugee camps had indirect effect on health. Research by Akresh et al., (2020) concluded that cash transfer in refugee camps significantly increased the number of preventative health services visits, while unconditional cash transfers appeared not to have such an impact. Another systematic review conducted by Murray et al., (2018) exposed that there was very little evidence of impact of unconditional cash transfers on refugees' health. Instead, cash transfers were assumed to facilitate

access to health services by reducing financial barriers because of the context in which the transfers were made (including timing, e g during pregnancy). Evidence showed that conditional cash transfers in refugee camps increased the utilization of health services.

Theoretical Framework

This study was conceptualized and theorized in accordance to explanations given by social systems theory (Von Ludwig Bertalanffy, 1968), resilience theory (Aoron Antonovsky, 1979) and the social development model expounded (Dominelli, 1997 and Midgley, 1995).

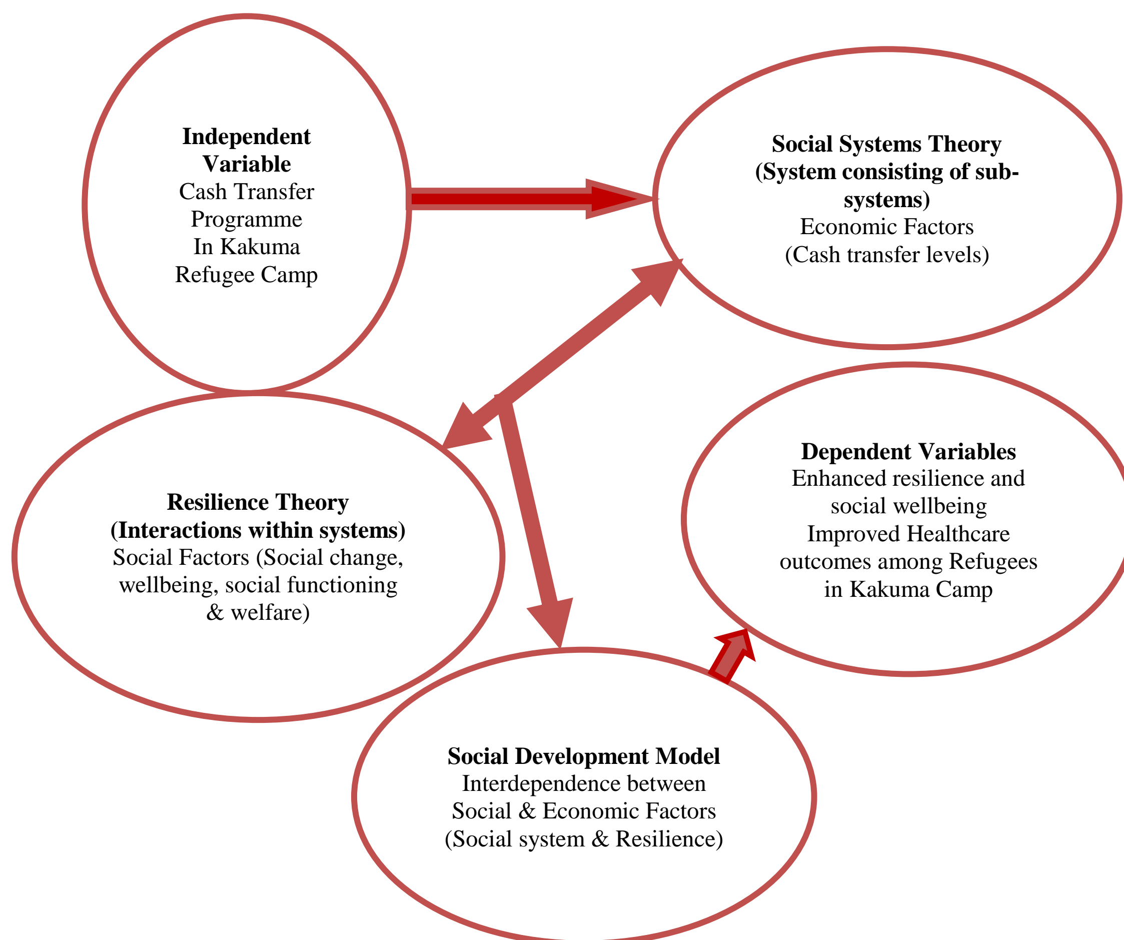

Figure 2: ***Conceptualized interplay between Social Systems Theory, Resilience Theory and Social Development Model***
Source: Own conceptualization, 2021

1.7 Methodology

Research Design

This was a convergent parallel mixed method study that adopted quantitative and qualitative research design during the research objective construction, questions formulation, data collection, analysis and interpretation. This study employed a pragmatism worldview.

Site Description

The study site was Kakuma refugee camp. Kakuma Camp is located in Kakuma town, Turkana West in Turkana County of the north western region of Kenya, 120 kilometres from Lodwar county headquarters and 95 kilometres from the Lokichogio Kenya-Sudan border. This is the site of a UNHCR refugee camp, established in 1969. Kakuma camp is separated into four sub-camps - Kakuma I, II, III, IV and Kalobeyei settlement. Kakuma refugee camp is situated around 500 metres from Kakuma Town in Turkana West Sub-County. Kakuma refugee camp was built in 1991 for Sudanese refugees fleeing the Sudan conflict. The Kakuma area has since grown to accommodate over 185,000 refugees and asylum seekers from across East and Central Africa. The bulk of registered refugees in Kakuma Camps 1-4 (147,822) hail from South Sudan (55%), Somalia (22%). The rest of the residents of Kakuma come from the Democratic Republic of Congo (DRC: 7.2%), Sudan (6.4%), Burundi (5%), Ethiopia (4%), followed by Eritrea, Uganda, and Tanzania (UNHCR Kakuma, 2020). In 2012, the Kakuma camp surpassed its capacity of 100,000 refugees. In 2015, UNHCR and the Government of Kenya agreed to pilot a new approach by developing a settlement at Kalobeyei, 20 km from Kakuma. UNHCR estimates that Kalobeyei will eventually host a local population of 20,000 and a refugee population of 60,000 (Oka et al, 2019). In this study, "Kakuma refugee camp" refers to Kakuma camp as well as Kalobeyei settlement.

Study Population and Target Population

The study population entailed refugees enrolled in the cash transfer programme and were being served by humanitarian agencies within Kakuma refugee camp, refugee community leaders, GOK department and humanitarian agencies engaged in the cash transfer programme and nutrition security among refugees within Kakuma camp. According to UNHCR, (2020) Kakuma refugee camp is divided into four sections; Kakuma I-IV and Kalobeyei settlement (In this study, the sections and settlement were referred to as the sub-camps. Thus, Kakuma refugee camp has 5 sub-camps). UNHCR, (2020) note that Kakuma refugee camp host around 185,615 refugees who are spread in administrative blocks. Therefore, Kakuma camp is composed of sub-camps, a sub-camp is composed of zones while a zone is composed of blocks which host the refugee households. However, Kalobeyei settlement is made up of villages, a village is composed of neighbourhoods, a neighboured is composed of compounds while a compound is made up of households. All these administrative units are led by appointed community leaders among the refugees who act as a link between UNHCR and RAS as they implement projects and provide services to refugees. It is for this informative and knowledge base reason that this study purposed to use these administrative communal leaders and refugees enrolled in the cash transfer programme as the central target population.

Sample and Sampling Techniques

The target sample for this study was determined using a statistical formula by Yamane (1967), as shown in equation 1.1:

$n = N/(1+Ne^2)$ ……………………… equation 1.1

Where,

n = Corrected/desired sample size,
N = Population size (185,615 refugees including their leaders,10 UNHCR partners & GoK),
1 = Constant value
e = Margin of error (e = 0.05 at confidence level of 95%).
Thus, n = 185,626/(1 + 185,626*0.05^2) giving a sample size of 400 as the minimum.

In order to take care of any losses due to spoilage and lack of response, a 10% (40 respondents) attrition was added to the sample size making it 440 as guided by Hair et al, 2010 rule of the thumb.

Table 1: ***Summary of the sampling strategy of respondents by study population units***

Study population units	Estimated number of target population	Sample size	Sampling technique
Refugees in Kakuma camp	185,615 refugees (UNHCR, 2018)	-Kakuma 1 - (74) Refugees -Kakuma 2 - (74) Refugees -Kakuma 3 - (74) Refugees -Kakuma 4 - (74) Refugees -Kalobeyei - (74) Refugees (Sub-total = 370 Refugees)	Simple Random sampling Used Survey & Questionnaires
Refugees' community leaders in Kakuma camp	Refugees' community leaders spread in 4 sub-camps, 11 zones, 154 blocks, 3 villages, 96 neighbourhoods and 768 compounds (UNHCR, 2018)	-Kakuma 1 - (8) Zone Leaders -Kakuma 2 - (4) Zone Leaders -Kakuma 3 - (6) Zone Leaders -Kakuma 4 - (4) Zone Leaders -Kalobeyei - (3) Village Leaders (Sub-total = 25 Leaders)	Purposive sampling Used Interview Guides
Government Authority	Refugee Affairs Secretariat (GoK, 2021)	1 Key Informant from the social development section (Sub-total = 1)	Purposive sampling Used Interviews
Humanitarian Agencies	10 UNHCR affiliated agencies operating in Kakuma camp (UNHCR, 2018)	1 Key Informant each from 4 agencies handling nutritional security among refugees enrolled in cash transfer programme (Sub-total = 4)	Purposive sampling Used Interviews
	Total (N) = 185,626	**Total Sample (n) = 400**	

Source: Field data, 2021

Methods of Data Collection

Relevant data for this study was collected through primary and secondary methods. The data protection Act of Kenya (2019) guided the data collection procedures. To effect primary data collection, three instruments were used; interview, questionnaires and FGDs. Utilization of these methods of data collection enhanced validity and reliability of the study findings. The researcher enlisted the services of research assistants who underwent a two-day training on basic research techniques. The researcher collected secondary data from a variety of relevant sources to the study scope. This included UNHCR and affiliated humanitarian agencies library books, publications and articles, information from refereed journals and the GoK department of refugee affairs documents to complement primary data.

Reliability and Validity

To ensure reliability of the collected data by questionnaires, FGDs and interviews, triangulation was conducted. The content validity of tools was based on the research objective. Validity was also verified by comparing the results obtained through content analysis of the three instruments. The content validity was further examined by supervisors of the study and other scholars of the department

of social sciences of Catholic University of Eastern Africa where suggestions were made and adjusted accordingly. The researcher conducted a two-day training to take the research assistants through aspects of research and the tools while undertaking the study. The alpha coefficient for the reliability index was .839.

Pilot Study

The researcher carried out a pre-test of instruments within Lodwar town amongst refugees living with friends and relatives in Lodwar. The researcher used 37 refugees, 1 GoK staff and 2 NGO staff respondents in the pilot study because this made 40 (10%) of the sample size (400) as guided by Hair et al (2010) rule of the thumb.

Data Analysis Procedures

The study adopted a mixed methods design in an attempt to answer the stated objective and to complement insights discovered. The data protection Act of Kenya (2019) guided the data analysis procedures. SPSS version 27 was adopted to help in quantitative data analysis. This quantitative data was analysed using descriptive and inferential statistics. Specifically, the descriptive included frequencies, percentages and mean. Whereas the inferential utilized the ANOVA-one way analysis. Qualitative data was analysed using thematic analysis that entailed coding, transcribing, categorization, voices analysis and narrative analysis.

Ethical Considerations of the Study

The researcher was guided by the Kenya data protection Act (2019). In reporting verbatives for qualitative data, the study utilized pseudonyms for participants who appended their acceptance to participate in the study through a consent form. The researcher sought authority to research from the Directorate of graduate studies of Catholic University of Eastern Africa. The researcher sought a research licence from the National Commission for Science Technology and Innovation (NACOSTI), Turkana County Commissioner and Refugee Affairs Secretariat (RAS) permission so as to allow data collection in Kakuma refugee camp. The questions that were asked had no information of personal or political nature. An introduction caption and University student identification card by the researcher was used for self-identification and the study purpose clearly indicated to the respondents. The respondents were not obliged to write their names on the questionnaires. As a mechanism to curb any psychological harm that may arise in the event of interview or data collection, this study adhered to the social work code of ethics, principles and values.

1.8 Data Presentation and Interpretation of Findings

Cash transfer role on affordability of health services among refugees

In order to intellectualize the refugees' access to quality healthcare, the researcher pursued to establish whether the cash transfer programme had a positive role on affordability of health services among refugees benefitting from the cash transfer programme in Kakuma camp. The responses were as presented in figure 3.

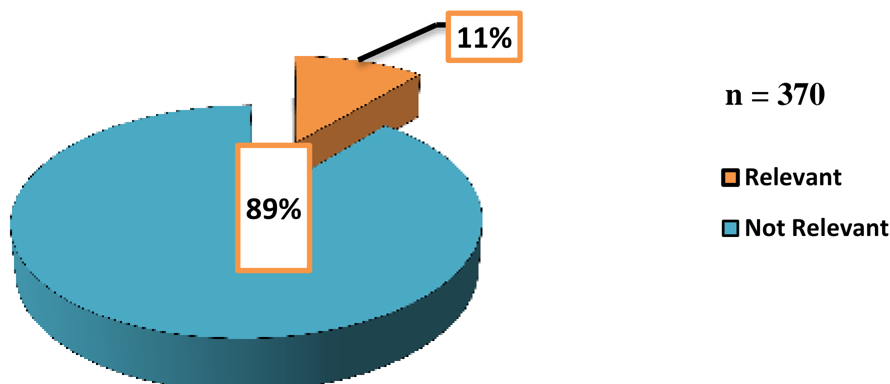

Figure 3: ***Cash transfer role on affordability of health services among refugees***
Source: ***Field data, 2021***

The study results indicated that out of the 370 respondents interviewed a minority of 40 (11%) acknowledged that cash transfer had the ability to help them afford health services within Kakuma camp. This is because the respondents were able to use part of the amounts to cater for their health needs especially during emergencies. A majority of 330 (89%) of the respondents were of the contrary opinion because they claimed that the cash transfer was particularly meant for food and not health needs since UNHCR through Red Cross and International Rescue Committee were mandated to provide free health services to refugees. As established by FGDs with community leaders, healthcare challenges seemed to be numerous among refugees in Kakuma camp regardless of the UNHCR interventions. The study further established that the 40 (11%) who attested that cash transfer had the ability to help them afford health services within Kakuma camp, claimed that they only managed to spend below Ksh.1000 monthly on health-related issues like; buying medicines, transport to hospital and paying for health services mostly within Kakuma town private clinics and chemists. Shazia, et al, (2021) study tend to assent to the notion that cash transfer alleviates the financial burden of accessing healthcare services by providing refugee households with a regular income.

An interview participant insisted that;

> Our problem is not treatment and basic health services as such, it's the transport, distant appointments, and lack of specializations in Kakuma camp clinics. I know we as refugees have a chance at government hospitals in Kakuma town, Lokichogio and Lodwar but the line is too long, and the appointments are not easy, plus having to pay for transportation **(P 9, 11/2021).**

From this statement, the study learnt that refugees not only have hardships in affording quality healthcare but also face challenges of accessing the health services.

Interview with key informants informed the study that health services for refugees in Kakuma camp were offered freely by UNHCR implementing partners hence not pegged on the cash transfer programme. For instance, the International Society of Red Cross, Kenya handled health facilities and healthcare services in Kalobeyie settlement and new arrivals reception centre while the International Rescue Committee performed the same function in Kakuma 1-4. A reception centre officer of Red Cross noted that Kakuma camp had seven health facilities which were known as clinic 1, 2, 3,4, 5, 6 and 7 distributed within the sub-camps. Clinic 7 was the highest-level health facility which handled referrals from the other lower-level health facilities within Kakuma refugee camp.

The narration by P 202, (11/2021) was also supported by a zone leader who said that;

> In Kakuma clinic 4, most sickness are not treated there. Likewise, there are limited clinics in the camp, for example Kakuma 1 and 4 sub-camps are served with only one clinic thus due to

the large population, a patient can que for up to 6 hours before being served. Equally some medical attendants cannot speak English or other languages like French and Arabic hence making it hard to manage refugee patients from diverse nationalities. With this in mind, as a camp community leader, I suggest that refugees should allowed to withdraw cash to enable them access quality healthcare services".

(P 12, 11/2021).

The impact of the cash transfer on health issues mainly relates to the cost of obtaining healthcare. Receipt of the cash transfer may free up other sources of income that can be used on health, but due to the low transfer level it has limited impact potential. The effect of the cash transfer on obtaining specialized treatment of refugees is limited, since these are rarely covered by subsidized healthcare services provided by government services or charities (NRC, 2018b). In France, the health system aims to be inclusive and accessible to migrant patients. As such, the same principles apply to legal residents as to French citizens. Asylum seekers are also covered by the universal free health insurance system (Shazia et al., 2021).

This study was in consensus with a refugee health situation analysis conducted by Jemutai et al., (2021) who established that refugees in Kenya generally experience challenges in access to healthcare, whether they are in the rural camp complexes like Kakuma/Kalobeyei, or Dadaab or urban areas like Nairobi. Nonetheless, those in the camps are slightly better off, as these settings are generally designed to provide humanitarian assistance to the refugees including health, education and livelihood opportunities, among others. Such elaborate refugee dedicated systems do not exist in urban settings and refugees are often left on their own to fend for themselves and their families. Although the 2010 Constitution of Kenya stipulates the right to health for every person in Kenya, refugees continue to experience unique barriers in accessing healthcare (Jemutai et al., 2021).

Cash transfer role on accessibility to health services among refugees

The study was interested in examining the role of cash transfer on accessibility to health services among refugees enrolled in the cash transfer programme in Kakuma camp. Since health services are provided freely by UNHCR implementing partners, this study focussed on health accessibility in relation to access to health referrals and specialized health services outside Kakuma camp. The responses were as shown in figure 4.

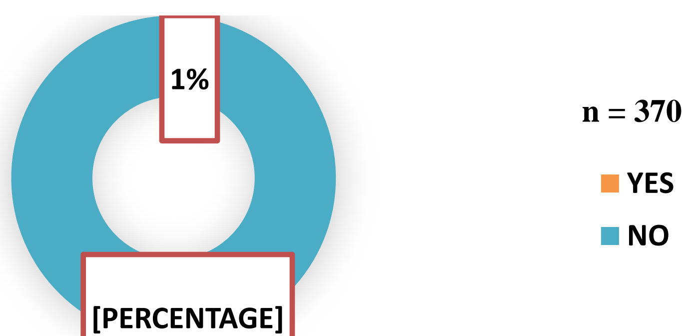

Figure 4: ***Cash transfer role on accessibility to health services among refugees***
Source: ***Field data, 2021***

Results in figure 4 showed that a minute portion of only 5 (1%) out of the 370 interviewed respondents indicated that cash transfer programme had the ability to enable them to access health referrals and specialized health services outside Kakuma camp. This capability was necessitated by some special targeted cash-based projects from specific humanitarian agencies that provided funding to most vulnerable refugee households hence enabling them be in a better position to cater for health referrals. On the other side of the coin a big share of 365 (99%) respondents rejected the ability of cash transfer programme to enable them access health referrals and specialized health services outside Kakuma camp because they claimed that referrals need a lot of resources that one can't afford to save from the cash transfer disbursed. The researcher further established that the 5(1%) who confirmed that cash transfer had the ability to enable them to access health referrals and specialized health services outside Kakuma camp, claimed that they only managed to use it for transportation to health facilities in Kakuma town, Lodwar, Eldoret and Nairobi.

These findings were in a disagreement with the statement of a key informant 02 who claimed that cash transfer indirectly influenced health of refugees. The informant stated that, through WFP food vouchers and nutritious porridge project refugees access diet which eventually enhance their health status and reduce diseases like malnutrition, marasmus and kwashiorkor especially among children. Key informant 03 added that in case of emergencies and referrals for specialized treatment among refugees, arrangements are made for transportation to health facilities outside Kakuma camp. Nonetheless, one FGD participant was equally in a disagreement with this position as she claimed that many refugees have died in the camp homes or health facilities awaiting transportation and referral procedures and processes that usually take long time.

This statement was emphasized by an interview participant who said that;

> Most refugees prefer seeking medical attention at Kakuma Mission hospital in town than Kakuma camp health clinics which they claim that there are poor services that has made many refugees loose lives. In most cases refugees divert cash transfer meant for food to pay medical costs in private clinics in Kakuma town **(P 23, 11/2021).**

In a cross-sectional study conducted by Megan Doherty et al, (2020) on refugees with serious health problems who sought health referrals (*n* = 156, 53% male) and caregivers (*n* = 155, 69% female) living in Rohingya refugee camps in Bangladesh, using convenience sampling to recruit participants at the community level, it was established that the most commonly referred health issue for specialized medical attention outside the camp environs were physical disabilities (*n* = 100, 64.1%), treatment-resistant tuberculosis (TB) (*n* = 32, 20.5%), cancer (*n* = 15, 9.6%), and HIV infection (*n* = 3, 1.9%) (Megan Doherty et al, 2020). This study found out that referral costs were majorly covered by the refugees themselves with little or no assistance from the UNHCR cash transfer programme (Megan et al., 2020). Chaaban et al., (2020) in their study on Multi-Purpose Cash Assistance impact in Lebanon on Syrian Refugees found a significant increase in access to primary healthcare by 8.3 percentage points (from 82% to 90.3%). Specifically, an improvement in access to primary healthcare for children under 5 (from 87.5 per cent to 99.5 per cent, (p-value 0.014) and children aged 5 to 19 years (from 83.5 per cent to 92.7 per cent, (p-value 0.066) was noted.

Cash transfer role on responsive healthcare among refugees

The study sought to determine whether the cash transfer programme had a positive effect on responsive healthcare among refugees in terms of management of health emergencies in Kakuma camp. The responses were as displayed in figure 5.

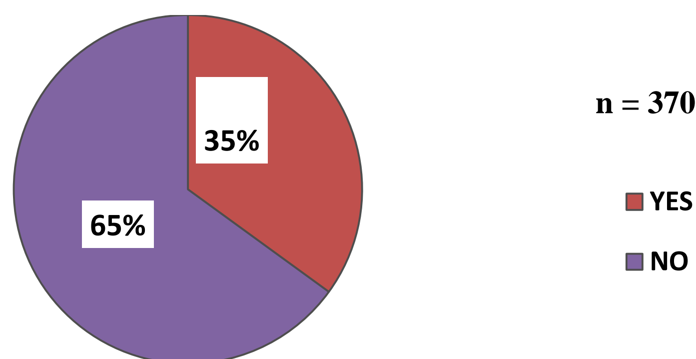

Figure 5: ***Cash transfer role on responsive healthcare among refugees***
Source: ***Field data, 2021***

Findings in figure 5 revealed that out of the 370 respondents that were interviewed in Kakuma refugee camp, 130 (35%) claimed that the cash transfer programme enabled them respond to and manage health emergencies. This was evident among the respondents who received unrestricted cash transfers because they could easily divert the ATM money meant for food to cater for health emergencies. On the other hand, 240 (65%) had a contrary opinion because the BC money especially in Kakuma 1-4 was restricted to be used in selected BC agents and shops who didn't own chemists but only sold food stuffs and perhaps pain killers hence couldn't help in times of health emergencies.

Relatively, a study conducted in Ghana refugee camps by de Boer and Zieck (2020) established that Ghana's cash transfer program increased the use of curative healthcare by 24% among children aged 0-5 years in refugee households. This increased use of health services could be attributed to the high enrolment in refugees in the national health insurance scheme (NHIS), a scheme which allowed registered members to have access to free healthcare. Enrolment into the NHIS, was a condition that beneficiaries were required to meet in this program (de Boer et al., 2020). Basically, cash transfer when integrated with health insurance enhanced refugees' access to quality healthcare.

These results were not in tandem with the position of a key informant who said that;

> LWF has a cash transfer project targeting most vulnerable and unaccompanied minors who are supported with Ksh.3000 per month to cater for non-food expenses including health emergencies. This cash-based support is allocated to every child in the registered household of which the monthly total amount is disbursed through an ATM/BC line of the household representative (head) who is normally a parent or a responsible identified adult caregiver/guardian. This project has really gone a long way in promoting responsive healthcare among vulnerable households within and outside Kakuma refugee camp (**KI 05, 11/2021).**

During FGDs with camp community leaders the study was informed that most refugees used the cash transfer income to manage health emergencies like diarrhoea, coughs and malaria. An interview with key informant 03 revealed that refugees in large family sizes receive a considerably huge amount of money which they utilize part of it for responsive healthcare. One FGD participant posed a question that, "how can one take food when sick?" The FGD participant added that some refugees collude with *Bamba Chakula* shop agents to get drugs instead of food while those using ATMs do easily convert money meant for food to take care of health emergencies.

In a contrary opinion an interview participant stated that;

> Cash transfer programme has little impact on enhancing quality healthcare among refugees because the amount is usually little to even take of monthly food needs leave alone health emergencies refuges experience in Kakuma camp **(P 8, 11/2021).**

The study findings were in support of a UNHCR study conducted in 2017 on health access and utilization survey (HAUS) among 591 refugees and asylum-seekers living in Malaysia (UNHCR,

2020). Based on the survey results, 45.2% of those refugees who sought healthcare went to government health facilities, 43.3% went to private facilities, and the remaining 11.5% went to facilities run by non-governmental organizations (NGOs). Overall, 26.7% of those with chronic conditions including hypertension, asthma or chronic obstructive pulmonary disease, and Type 2 diabetes mellitus were not able to seek treatment for their conditions (UNHCR, 2020). Subsequently, Sterk (2020) in a demographic study in Kalobeyie settlement revealed that health problems were frequent among South Sudanese refugees: 18% of respondents reported severe difficulties standing up for 30 minutes or walking one kilometre (23% of women), and 23% had poor mental health according to the PSQ-9 scale (27% of women). In the year before the survey, 28% of the households had suffered from at least one health shock.

FGDs conducted on community leaders revealed that refugees faced several challenges in accessing quality healthcare in Kakuma refugee camp. The challenges mentioned included; inadequate health personnel and drugs in Kakuma health facilities, long patient ques in camp health facilities, long distance to health facilities especially during emergencies, lack of resources including money and transportation to attend specialized health referrals outside Kakuma and communication barrier between health personnel and various refugee nationalities in Kakuma camp. In addition, the community leaders went ahead to reinforce that cash transfer programme did not enable refugees in Kakuma camp access quality healthcare because the cash transfer is restricted to food only, so it doesn't help refugees access healthcare thus some refugees use some of the cash transfer income meant for food to cater for referrals outside Kakuma and treatment in private health facilities in Kakuma town.

On this lane, the researcher noted that, with regards to governance of refugee health issues, the UNHCR and RAS, Kakuma play an important role in administrating the refugee camps in partnership with the Turkana County government. Healthcare in the refugee camp complexes is overseen by UNHCR and largely provided free-of-charge through a range of NGO partners. For example, the International Rescue Committee runs a general hospital in the Kakuma camp. Although dedicated health facilities for refugees are available within the refugee camps in Dadaab, Kakuma and Kalobeyei, they appear to be inadequate when compared with the population they are intended to serve. For example, a health 2017 survey among newly arrived South Sudanese refugees and host populations in the refugee settlements of Kakuma and Kalobeyei found that refugees had a limited number of clinics available to them, and often waited in long queues to receive usually inadequate care (Sannoh, 2020).

Strategies to enhance access to quality healthcare among refugees

In an effort to assess the effect of cash transfer programme on social development it was important for this study to forge ahead and collect opinions from enrolled and benefitting refugees on how quality healthcare can be enhanced by the cash transfer programme in Kakuma refugee camp. These opinions were demonstrated in table 2.

Table 2: ***Strategies to enhance access to quality healthcare among refugees***

Strategy		
UNHCR to consider a cash transfer project that supports health insurance cover for healthcare outside Kakuma camp	92	25
Increase cash transfer amount to enable refugees get balanced diet and sort out minor illness hence quality health	222	60
Refugees to be allowed to withdraw part of cash transfer to cater for health emergencies	56	15
Total	**370**	**100**

Source: *Field data, 2021*

These strategies were in agreement with those of FGDs participants who suggested that UNHCR should include the component of healthcare in the cash transfer programme and provide some additional funds to households to cater for health referrals. Consequently, the FGDs participants felt that the cash transfer programme should be designed in a manner that cater for health insurance covers and in particularly for refugees needing specialized health attention outside Kakuma camp and those suffering from terminal diseases like cancer which need extensive resources for treatment. On the same lane, the key informants also had suggestions on how access to quality healthcare among refugees can be enhanced by the cash transfer programme in Kakuma camp. Their responses were as follows; before enrolment into the cash transfer programme, refugees should undergo a vigorous health assessment to establish their health conditions that could be factored in the cash transfer programme to enable them access quality healthcare. They also emphasized that the health system should be improved if relevant stakeholders' channel more funding into healthcare in Kakuma refugee camp.

One interview participant insisted that;

> If UNHCR can allow me to withdraw the money from my BC line to Mpesa, it could assist me and my family manage health emergencies. For example, I have malaria now and I don't have money to buy drugs or transport to reach clinic seven
> **(P 25, 11/2021).**

The challenges of refugees in relation to health seems numerous in Kakuma camp thus compromising the quality of healthcare among refugees.

In a rather controversial but realistic statement, another respondent said that;

> I was given wrong drugs because we could not communicate with the nurse on duty. She was talking French and myself Arabic. Seemingly, the nurse just gave me the available drugs after guessing from my body temperature that I could be having malaria. I didn't get better anyway (**P 2, 11/2021).**

Given the unique challenges experienced by refugee populations in accessing healthcare services, Jemutai et al., (2021) suggests that, integrating refugee health within the broader Kenyan health system could be beneficial and promote more rational use of limited available resources. An integrated refugees and host population health system can be defined as the provision of health services to both refugees and host populations alike, within the structure of the host country's health system, in a way

that refugees and host population can access the same healthcare resources from the same providers (Jemutai et al., 2021).

As noted with Jenkins (2020) integrated health model contrasts with the parallel refugee-centred health system model - such as that observed in Kenya - that is separate from the host country health system, with health facilities and services largely managed and provided by humanitarian organisations. Thus, an integrated health system should be built on principles such as equitable access to health services, equality and non-discrimination among others, as articulated in the WHO's framework for 'promoting the health of refugees and migrants. These principles are aligned with the 2030 Agenda for Sustainable Development of leaving no one behind, and the health-related commitments in the CRRF. Jenkins (2020) avert that within an integrated health system, limited resources (financial, technical) are better maximised for quality healthcare provision. It can also reduce the risk of tensions around perceived inequality in access and quality of healthcare between refugees and host populations, and improve integration and cohesion between these groups. Additionally, channelling international resources through the host country's health system could, in the long term, strengthen the system and build refugees resilience (Jenkins, 2020).

Relationship between cash transfer programme and quality healthcare

To establish the relationship between cash transfer programme (independent variable) and access to quality healthcare as a measurable indicator of social development (dependent variable) among refugees in Kakuma camp, the researcher tested hypothesis using ANOVA one way and Analysis of variance. To test the hypothesis, the researcher used 5% level of significance of variance test since it is appropriate for comparing more than two means. The hypothesis was formulated as follows:

H_0: There is no significant relationship between cash transfer programme and access to quality healthcare among refugees in Kakuma Camp.

H_1: There is significant relationship between cash transfer programme and access to quality healthcare among refugees in Kakuma Camp.

Table 3: ***ANOVA-One Way test of relationship between cash transfer programme and access to quality healthcare among refugees***

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	.233	1	.233	2.800	.133
Within Groups	.667	369	.083		
Total Between Groups	.900 .686	370 1	.686	3.200	.111
Within Groups	1.714	369	.214		
Total	2.400	370			

Table 3 shows that the P- value > 0.05 for one-way Anova on the relationship between cash transfer programme and access to quality healthcare among refugees in Kakuma Camp. Creswell (2007) guides that when the P- value is greater than 0.05 level of significance, it implies that there is a significant relationship between the independent and dependent variables. In this case, since the P-value (0.133 and 0.111) were greater than 0.05 level of significance, the study therefore concludes that there is a significant relationship between cash transfer programme and access to quality healthcare among refugees in Kakuma camp. The study therefore rejects the null hypothesis. These findings mean that if the cash transfer level is increased then access to quality healthcare would increase as well among refugees.

These results were in tandem with a WHO (2021) longitudinal cohort study that compared the effects of cash transfers and health education interventions among Syrian refugees in Jordan and found out that cash transfer participants had the highest expenditures at endline and were the only group with statistically significant increases in payments for outpatient diabetes care (25.3%, P<0.001) and monthly medication costs (13.6%, P<0.001). Conversely, monthly spending on diabetes medication decreased significantly in the cash transfer only group (-18.7%, P=0.001). Specialist visits also increased among cash transfer participants (16.8%, P =0.001), but decreased in non-cash transfer participants (-27.8%, P<0.001) (WHO, 2021). This mean that cash transfers are an increasingly common intervention in the refugee response to meet basic needs and have potential secondary impact on health outcomes.

1.9 Conclusions

The cash transfer programme has not had much contribution on improving access to quality healthcare among refugees in Kakuma camp. The impact of cash transfer was too little because it mostly related to the transportation to health facilities. Again, cash transfer level was insufficient to cover anything beyond small ailments, such as operations, referrals or expensive treatments. Cash transfer basically targeted food, so it did not help refugees access quality healthcare thus most refugees opted to use some of cash transfer meant for food to cater for health needs. Thus, there existed significant relationship between cash transfer programme and access to quality healthcare among refugees in Kakuma camp.

1.10 Recommendations

This study recommends that UNHCR and its partners and GoK should strategize to include the component of healthcare in the cash transfer programme by providing supplementary funding to households to cater for healthcare. Subsequently, health insurance covers for refugees should be integrated in the cash transfer to facilitate specialized healthcare outside Kakuma camp and aid refugees suffering from terminal diseases like cancer which need extensive resources for treatment.

References

Agier, M., & Lecadet, C. (2014). *Un Monde de Camps.* Paris: La Découverte.

Alix-Garcia, Jennifer, Erhan Artuc, and Harun Onder. (2017). The *Economics of Hosting Refugees: A Host Community Perspective from Turkana.* Washington DC: World Bank.

Akresh, R, D De Walque, and H Kazianga, (2012) Alternative Cash Transfer Delivery Mechanisms: Impacts on Routine Preventative Health Clinic Visits in Burkina Faso discussion Paper no 6321 bonn: IZa available at: http://ftp iza org/dp6321 pdf

Aker, J. (2012) Examining Differences in the Effectiveness and Impacts of Vouchers and Unconditional Cash Transfers. Concern Worldwide and Tufts University.

Betts, A. et al (2018a). *Self-Reliance in Kalobeyei? Socio-Economic Outcomes for Refugees in North-West Kenya.* (Oxford: RSC).

Betts, A., N. Omata, and O. Sterck. (2018b). *Refugee Economies in Kenya*. Refugee Studies Centre, University of Oxford.

Çorabatır, M.& Hassa, F. (2013). Report on the Activities of Non-Governmental Organizations for Syrian Refugees in Turkey. Research Centre on Asylum and Migration.

Chaaban, J., Salti, N., Ghattas, H., Irani, A., Ismail, T., & Batlouni, L. (2016). Survey on the socioeconomic status of Palestine refugees in Lebanon 2015. Retrieved from https://www.unrwa.org/sites/default/files/content/resources/survey on the economic status of Palestine refugees in Lebanon 2015.pdf

Delius, A., and Sterck, O. (2020). Cash Transfers and Micro Enterprise Performance: Theory and Quasi-Experimental Evidence from Kenya. SSRN Working Paper

Fox, J, and C. Kamau. (2013). *The Dadaab Dilemma: A Study on Livelihood Activities and Opportunities for Dadaab Refugees*. Danish Refugee Council.

Goitom, H. (2017, March 8). *Kenya: Government's Attempt to Close Refugee Camps Found Unconstitutional.* Retrieved from Library of Congress: http://www.loc.gov/law/foreign-news/article/kenya-governments- attempt-to-close-refugee-camps-found-unconstitutional/

Government of Kenya. (2006). Kenya Refugees Act. Retrieved from http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/RefugeeAct

Government of Kenya. (2019). Kenya Data Protection Act. Retrieved from http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/DataprotectionAct

Harvey, P. and S. Bailey (2011) Cash Transfer Programming in Emergencies, Good Practice Review 11. Humanitarian Practice Network, Overseas Development Institute.

Haushofer, J., & Shapiro, J. (2016). The short-term impact of unconditional cash transfers to the poor: experimental evidence from Kenya. The Quarterly Journal of Economics, 131(4), 1973-2042.

IFC. (2018). *Kakuma as a Market Place. A Consumer and Market Study of a Refugee Camp and Town in Northwest Kenya*

Kimetrica. (2016). *Refugees Vulnerability Study, Kakuma, Kenya.*

Ludwig, B. (2016). "Wiping the Refugee Dust from My Feet": Advantages and Burdens of Refugee Status and the Refugee Label. *International Migration, 54*(1), 5-18.

Midgley, J. (2014). *Social development: Theory and practice.* Thousand Oaks, CA: Sage Publications, Inc.

NRC and IHRC. (2018a). Supporting Kakuma's Refugee Traders: The Importance of Business Documentation in an Informal Economy," Briefing Paper, August 2018.

NRC and REACH. (2018). "Dadaab Assessments June-September 2018."
REACH. (2018). *Multi-Sector Needs Assessment: Dadaab Refugee Complex Garissa County, Kenya.*

Samuel Hall. (2016). *Comprehensive Market Assessment for Kakuma Refugee Camp.* Commissioned by DRC, AAH-I, and UNHCR Kenya.

Sanghi, Apurva, Harun Onder, and Varalakshmi Vemuru. (2016). "*Yes" In My Backyard? The Economics of Refugees and Their Social Dynamics in Kakuma, Kenya.* World Bank Group, Washington D.C.

UNHCR, (2018). *The Kalobeyei Integrated Socio-Economic Development Programme: Phase One: 2018-2022 Comprehensive Refugee and Host Community Plan in Turkana West*.

World Bank Group. (2019). Desk Review on Livelihoods and Self-Reliance for Refugees and Host Communities in Kenya

World Food Programme, (2016). Cash based transfer market assessment of May 2016. Cash based transfer response options in Nyarugusu refugee camp, United Republic of Tanzania

Yamane, Taro. (1967). Statistics: An Introductory Analysis, 2nd Ed., New York: Harper and Row.