RESEARCH REPORT

Who Gets Care and Who Doesn't? Migrants and Healthcare Access Under Climate Stress in Kenya and South Africa

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Climate stress is exposing how healthcare access is structured in Kenya and South Africa. This report shows that access is not determined by need alone, but by how systems recognise individuals and apply entitlement. Despite different governance approaches, both countries produce uneven access. As mobility increases, health systems organised around fixed populations are misaligned with emerging patterns of vulnerability.

Key Findings

- In Kenya, access to care often breaks down at the point of identification, where refugee documentation is not recognised across health, insurance, and digital systems.
- In South Africa, access is inconsistent, with similar patients receiving different treatment depending on the facility or staff member.
- In both countries, migrants delay or avoid care due to cost, documentation barriers, or fear of being turned away.
- Climate-related events increase demand but leave existing barriers to access unchanged.
- As a result, those most exposed to climate-related health risks face the greatest difficulty accessing care.

Recommendations

- Move beyond citizenship-based entitlement so healthcare access reflects population mobility.
- Integrate refugee and migrant healthcare into national systems instead of relying on parallel humanitarian services.
- Reduce frontline discretion by enforcing clear, consistent standards for access across facilities.
- Plan health systems around changing populations, including mobility, urban growth, and climate-related disruption.
- Align climate, migration, and health policy so responses are coordinated rather than fragmented.
- Treat administrative barriers and inconsistent implementation as core obstacles to healthcare access.

Executive Summary

Climate change is not only increasing health risks in Kenya and South Africa; it is exposing how access to healthcare is organised when systems come under pressure. Across flooded informal settlements, overcrowded clinics, and drought-affected regions, the question is no longer simply whether healthcare exists, but who is able to reach it, enter it, and be recognised within it.

Evidence from both countries shows that health systems do not respond to medical need alone. Access is shaped by administrative processes, documentation requirements, and decisions made at the point of service. As floods, droughts, and extreme heat increase demand for healthcare, migrants, refugees, and other mobile populations often encounter systems that were not designed with mobility in mind. The report identifies two distinct governance patterns. In Kenya, access is shaped primarily through administrative recognition. Refugees, asylum seekers, and other displaced populations must be visible within state systems to obtain healthcare, yet fragmented databases, documentation barriers, and parallel humanitarian structures continue to limit this recognition. In South Africa, access is formally guaranteed but unevenly applied. Legal entitlement exists, but healthcare access is frequently shaped by frontline decisions, documentation checks, institutional discretion, and uncertainty over who belongs within an already overburdened system.

Despite these differences, the outcome is similar. Access becomes conditional rather than guaranteed, and those most exposed to climate-related risks are often the least able to obtain care. Climate stress does not

create these inequalities, but intensifies them by placing greater pressure on systems that already organise access unevenly.

These findings reveal a major policy gap. Health systems continue to be planned around stable, citizen populations, while climate change is increasing mobility and concentrating vulnerability in urban areas. Climate policy, migration governance, and health planning remain poorly aligned, limiting the ability of institutions to respond to changing patterns of movement, settlement, and need. Addressing this requires more than expanding services or improving emergency response. It requires rethinking how access itself is organised. Administrative barriers that limit recognition must be reduced, inconsistent implementation at the point of care must be addressed, and health systems must begin planning for mobility as an ongoing condition rather than an exception. Without these shifts, climate stress will not only increase pressure on healthcare systems, but deepen the uneven ways in which care is delivered and withheld.

Why this matters now

Climate change in Africa is no longer a future concern; it is already reshaping public health systems and the conditions under which healthcare is accessed. Across Kenya and South Africa, floods, droughts, and extreme heat are increasing in frequency and severity, placing sustained pressure on infrastructure, services, and population stability.[1] Yet these pressures are not experienced evenly. As climate-related shocks intensify, they are exposing how healthcare systems manage access when demand rises and resources become strained.

In Kenya, recurrent floods and prolonged drought cycles have contributed to both displacement and service disruption. Flooding in 2020 displaced more than 254,000 people, while further flooding in 2023 again overwhelmed local health facilities[2]. In arid and semi-arid regions, prolonged drought has undermined livelihoods, increased food insecurity, and heightened vulnerability to illness and malnutrition[3]. In South Africa, more than 50 major disaster events were recorded between 2008 and 2022, including the devastating KwaZulu-Natal floods, which displaced over 40,000 people and caused extensive damage to clinics, hospitals, and water infrastructure[4]. These events disrupted not only emergency response capacity, but continuity of care, limiting access to treatment and routine services across affected communities.

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These pressures are reshaping both health risks and patterns of movement. Across both countries, flooding, drought, and livelihood loss are contributing to increased urbanisation as affected populations move in search of work, shelter, and services. Kenya hosts approximately 500,000 refugees, many of whom now reside in or near urban areas, while South Africa is home to more than 2 million migrants from across the region[5]. Climate-related shocks in neighbouring countries, including droughts and cyclones, are increasingly intersecting with broader drivers of cross-border mobility into South Africa[6]. Climate stress is therefore not a single event, but a continuing condition shaping where people live and how they attempt to access services.

Health risks are intensifying alongside these shifts. Flooding and poor sanitation contribute to outbreaks of waterborne disease, while overcrowded settlements

When demand rises under climate stress, healthcare systems do not expand access, they reveal how access is already decided.

increase exposure to respiratory and communicable illnesses[7]. Heat exposure further compounds these risks, particularly for populations living in informal housing or working in outdoor and informal sectors[8]. Field evidence from both countries indicates that disease outbreaks, including cholera and malaria, have increased following recent flooding events, placing additional pressure on already overstretched health facilities .

These pressures are unfolding within health systems that were already under strain. In South Africa, approximately 80% of the population depends on an under-resourced public healthcare system[9]. In Kenya, the devolution of healthcare to county governments has produced uneven levels of infrastructure, staffing, and service provision across regions[10]. Under these conditions, even moderate increases in demand can disrupt routine service delivery.

However, the challenge is not only one of capacity. Access to healthcare is shaped by systems of recognition and eligibility. In both Kenya and South Africa, health systems continue to operate around assumptions of stable, citizen populations. Documentation requirements, administrative procedures, and institutional coordination play a central role in determining who is able to access care. In Kenya, refugees often depend on humanitarian-supported services or specific forms of identification to access public healthcare[11]. In South Africa, although legal frameworks provide for access, migrants frequently encounter barriers at the point of service, including documentation checks, delays, and differential treatment[12].

Urbanisation intensifies these dynamics. Migrants and refugees are disproportionately concentrated in informal settlements where access to healthcare is shaped by distance, transport costs, overcrowding, and limited information[13].

These areas are often highly exposed to flooding, poor sanitation, and waste accumulation, increasing vulnerability to disease while limiting access to preventive and primary healthcare services[14]. Under such conditions, healthcare access becomes contingent not only on need, but on whether individuals are recognised within systems already operating under pressure.

Despite growing recognition of the links between climate change, migration, and health, policy responses remain fragmented. Climate adaptation strategies continue to prioritise infrastructure and environmental resilience, with limited attention to how climate stress affects healthcare access. Migration governance remains focused on regulation and documentation, while health system planning continues to rely on static population assumptions that inadequately account for mobility. As climate pressures intensify, these gaps are exposing not only capacity constraints, but the uneven ways in which healthcare access is organised across different populations. In this context, climate stress operates less as a standalone driver of outcomes and more as a condition that exposes and intensifies existing institutional weaknesses in how healthcare access is organised. These systems are structured around national identification frameworks, fixed population estimates, and territorially defined service delivery models, all of which assume relatively stable and formally recognised populations.

Research Approach

This report is based on a comparative qualitative study conducted in Kenya and South Africa between January and April 2026. The two countries were selected because they represent contrasting migration and governance contexts. Kenya operates a refugee-hosting model centred around camps and humanitarian aid.

Both countries are highly exposed to climate-related disruptions and rapid urbanisation, making them appropriate settings for examining how climate stress intersects with healthcare access for migrants, refugees, and other mobile populations.

Data collection combined interviews, field observation, and document review. In Kenya, fieldwork focused on Nairobi and refugee camp settings, particularly Kakuma, Kalobeyei and Dadaab. This allowed the study to capture experiences across urban refugee communities, camp-based refugee populations, and service providers working with displaced communities. In South Africa, fieldwork focused on Gauteng Province, particularly Johannesburg, and coastal areas of KwaZulu-Natal, including urban and peri-urban communities affected by recent flooding and climate-related disruptions.

The study engaged 62 participants, including refugees, asylum seekers, migrants, healthcare workers, humanitarian actors, community representatives and government officials working across health, migration and environmental sectors. Of these, 32 interviews were conducted in Kenya, focusing on Nairobi and refugee camp settings, while the remaining 30 interviews were conducted in South Africa, focusing on Gauteng and KwaZulu-Natal. Representatives of refugee-led organisations and community health promoters were also included to capture local experiences of healthcare access and service delivery.

Field observations in clinics, informal settlements, and refugee-hosting areas were used to complement interview data, alongside a review of policy documents, health data, and reports on climate-related events in both countries. This allowed the study to connect lived experiences of healthcare access with broader institutional and policy dynamics. All participants provided informed consent prior to participation, and ethical approval was obtained through a university ethics review process. Interviews were anonymised, and no identifying information is included in this report.

This study is exploratory and qualitative in nature. It does not aim to produce statistically representative findings, but rather to identify recurring patterns across selected sites and stakeholder experiences. The focus is on access to public healthcare systems rather than private provision. Despite these limitations, the study provides grounded insight into how climate stress, mobility, and healthcare governance intersect in practice. While the study is based on selected field sites, the consistency of patterns observed across Nairobi, Kakuma, Johannesburg, and Durban indicates that these dynamics reflect broader institutional tendencies rather than isolated cases.

Kenya: Climate Mobility and Health Access

When illness coincides with climate stress in Kenya, access to healthcare is not guaranteed; it is decided. In Kakuma, Dadaab, and Nairobi, refugees encounter systems that are simultaneously present and difficult to navigate, where the ability to receive care depends on more than medical need alone. As drought weakens livelihoods and floods drive disease outbreaks, clinics absorb rising demand, but outcomes diverge. Some patients move through the system with relative ease, while others are delayed, redirected, or excluded. This section draws on fieldwork to examine how these differences emerge, showing that under climate stress, access is shaped less by policy commitments and more by whether individuals are recognised within administrative and service delivery systems.

1. Climate pressure and healthcare access

In Kenya, climate stress is no longer episodic. Across Kakuma, Dadaab, and Nairobi, floods and prolonged droughts are reshaping patterns of illness while exposing how healthcare systems function under pressure[15]. These dynamics appear less as isolated crises and more as recurring cycles in which environmental stress, mobility, and weak service delivery reinforce one another.

In Turkana and Garissa counties, prolonged drought has undermined pastoral livelihoods, reduced food availability, and intensified malnutrition, particularly among children and pregnant women[16]. Health workers described recurring spikes in severe acute malnutrition during extended dry periods, especially among recently displaced populations from Somalia and northern Kenya. A health worker in Kakuma recounted treating a refugee infant with severe acute malnutrition whose family had fled drought conditions in Somalia, noting that "we see these every lean season."[17]

When rainfall follows these dry periods, the pattern shifts rapidly. Flooding contaminates water sources, overwhelms sanitation systems, and contributes to outbreaks of cholera, diarrhoeal disease, and malaria. Interviewees in the camps described repeated disease outbreaks following seasonal floods, while the 2023 flash floods led to a significant increase in malaria and cholera cases[18]. In Kakuma, an IRC health officer explained that after heavy rainfall in late 2024, "we suddenly had 30% more outpatient visits for water-borne disease."[19] Clinics were required to absorb sudden increases in demand despite limited infrastructure and staffing.

These pressures extend beyond camp settings. In Nairobi's informal settlements, including Kayole, heavy rainfall regularly causes flooding, sewage overflow, and deteriorating environmental conditions. Refugees living in overcrowded housing face increased exposure to respiratory and gastrointestinal illness, while poor drainage and weak infrastructure intensify health risks.

Climate stress is also reshaping patterns of movement. In northern Kenya, drought and livelihood collapse are pushing individuals toward refugee camps and urban centres in search of services and income opportunities. Local officials in Garissa similarly described cross-border movement linked to prolonged environmental stress in neighbouring Somalia[20]. These movements are placing additional pressure on healthcare systems already operating with limited capacity.

Within this context, healthcare access is shaped not only by the presence of services, but by the conditions under which individuals attempt to navigate them. In Kakuma and Dadaab, healthcare is primarily delivered through NGO-supported facilities providing maternal care, vaccinations, and treatment for common illnesses at no cost. As one IRC nurse explained, "every refugee knows they can get meds for free here; we are the primary source of healthcare." [21] However, these services remain limited in scope. Refugees requiring specialised or tertiary care must navigate referral systems involving transport costs, administrative procedures, and long travel distances. Several interviewees described selling livestock or relying on informal financial support to access treatment outside camp settings.

In urban areas, barriers are more directly administrative and financial. Nairobi alone hosts nearly 100,000 refugees and asylum seekers, many of whom rely on public healthcare facilities[22]. In practice, access often diverges from policy. Refugees reported being asked to provide Kenyan identification documents or referral letters before receiving

treatment, while others described being charged "foreigner" fees at public facilities. A Somali refugee recounted being asked to pay KES 5,000 (≈£30) for a referral letter at a provincial hospital, an amount that was financially inaccessible[23]. Local NGO workers explained that many refugees increasingly bypass public clinics altogether, instead seeking assistance through churches, humanitarian organisations, or informal support networks.

Financial exclusion further shapes access. Although Kenya's Social Health Insurance Fund (SHIF) is formally open to non-citizens, enrolment remains low due to contribution costs and documentation requirements[23]. Many refugees therefore rely on out-of-pocket payments or humanitarian assistance to access healthcare. Recent reductions in international funding have made these systems increasingly fragile, disrupting continuity of care for vulnerable households.

Box 1: Interrupted Care Under Funding Constraints

I have received help from the NCCK whereby they provided me with financial assistance to cater for my autistic son's treatment. With these funds, I was able to see a doctor at the Kenyatta National Hospital who assessed my son and said that my son's condition is treatable and would require a critical 6-month treatment plan. The treatment required 2 hospital sessions per week at KSH 1500 per session. However after one month, NCCK discontinued the aid due to the global funding cuts and I am unable to afford the payment required to continue the recommended treatment, as I am unemployed[25].
~ Congolese asylum seeker

These dynamics show that climate stress does not simply increase health risks. It exposes how access to healthcare is organised under pressure. Services may exist, but the ability to use them depends on environmental conditions, administrative procedures, and financial capacity.

2. Administrative recognition and exclusion

In Kenya, access to healthcare increasingly depends on whether individuals are recognised within administrative systems. For refugees and asylum seekers, this extends beyond documentation alone. Although refugees are formally registered through the Department of Refugee Services (DRS) and issued identification cards, these documents remain poorly integrated into national administrative systems[26]. A key constraint lies in the disconnect between the DRS and the National Registration Bureau (NRB), which manages the national identification registry. Because these systems do not effectively communicate, refugee documentation is often not recognised for accessing government services, including health insurance and digital healthcare platforms[27].

The consequences are immediate. Refugees reported difficulties registering for the Social Health Insurance Fund (SHIF), applying for work permits, opening businesses, or accessing digital government services. Many are therefore legally present but administratively invisible, excluded from systems that increasingly determine access to healthcare and other forms of public support.

This invisibility becomes most visible at the point of care. Interviewees repeatedly described situations in which access depended less on medical urgency than on documentation status. At public facilities, refugees without recognised identification were often charged additional fees, redirected elsewhere, or denied treatment entirely[28]. Several interviewees explained that they relied on Kenyan neighbours or local contacts to intervene on their behalf before receiving care, while others avoided hospitals altogether due to anticipated costs or rejection[29].

Box 2: When Identification Determines Access to Care

I remember one time when I had to go to the hospital as I was unwell but as soon as I got there, I was asked for my ID which they expected a Kenyan ID. When I produced my asylum seekers pass, I was asked if I had some 3,000 Kenyan Shillings so that I can be registered to see the doctor. I didn't have that amount but I had a SHA card (now SHIF) which I showed but they told me that they are not allowing the SHA card, cash only because they are not getting paid. When I insisted to be treated without the money, I was told that I had to pay first to access medical attention since am not Kenyan. This disappointed me and I left seeking to go to the nearby pharmacy where I explained my situation and I was able to get medicine[30].
~ Ethiopian asylum seeker

These experiences show how administrative requirements are enforced in practice. Documentation, payment systems, and institutional routines converge at the point of service, shaping who receives treatment and under what conditions. Even where refugees possess alternative forms of identification or insurance, these are not always recognised by frontline staff. One asylum seeker from the Democratic Republic of Congo described avoiding a hospital in Nakuru after being asked to produce a passport that had already been surrendered during the asylum process. Another refugee recalled being told, "No ID, no service," while waiting with a sick child until a Kenyan neighbour intervened[31].

Digitalisation is reinforcing these barriers. Kenya's healthcare system increasingly relies on electronic records and registration systems linked to national identification numbers. Refugees who lack recognised IDs or registered phone numbers are therefore excluded from systems that are becoming central to healthcare delivery. During the COVID-19 response, digital vaccine registration systems excluded many refugees who could not meet these requirements[32].

Administrative barriers are further complicated by decentralisation. Healthcare delivery is devolved to county governments, each of which exercises varying levels of discretion

in implementing national policy. In practice, this has produced inconsistent treatment across counties and facilities. One county official in the Rift Valley acknowledged that, in the absence of clear national guidance, local clinics often default to treating refugees as foreign nationals rather than as populations entitled to care under Kenyan law[33]. Health managers similarly reported uncertainty regarding whether refugees should be charged for services. As a result, healthcare access differs significantly across locations despite national commitments to inclusion.

Beyond identification, institutional gatekeeping continues to shape access. Kenya's health financing systems increasingly operate through formalised and digital mechanisms, including SHIF enrolment and electronic billing platforms[34]. Yet refugees remain largely excluded because enrolment frequently requires Kenyan national identification numbers. Consequently, many continue to depend on NGO-supported healthcare or out-of-pocket payments. As one county health official explained, public health budgets are designed around citizen populations, while refugees are expected to rely on humanitarian systems[35].

These challenges are reinforced by broader institutional fragmentation. Climate adaptation, migration governance, and healthcare planning continue to operate largely in isolation. In Garissa County, local health officials reported limited coordination between health services and disaster management authorities during flood responses[36]. Refugees displaced by flooding therefore remained heavily dependent on humanitarian actors for emergency support, water, and sanitation rather than integrated public systems.

Thus, these dynamics show that barriers to healthcare access are not simply the result of resource shortages. They are embedded within administrative systems, digital infrastructures, and institutional arrangements that determine who becomes visible within healthcare systems and who remains outside them. These dynamics were not isolated incidents but were consistently reported across interviews and field sites, pointing to recurring patterns in how administrative systems shape healthcare access.

3. Where policy commitments break down

Kenya has adopted increasingly progressive policy commitments on refugee inclusion and healthcare access, yet a persistent gap remains between these commitments and their implementation. The 2010 Constitution guarantees the right to health for "every person" and explicitly prohibits the refusal of emergency treatment[37]. Similarly, the 2021 Refugee Act and the Shirika Plan signal a shift toward development-oriented approaches that recognise refugees' socio-economic rights and their inclusion within national systems[38]. National health policies further emphasise universal health coverage, suggesting an intention to extend services across all populations.

However, these commitments remain unevenly realised in practice. Refugee healthcare continues to depend heavily on humanitarian actors rather than full integration into the public health system. Administrative systems still operate in parallel rather than in coordination. The Department of Refugee Services (DRS), for example, continues to rely on manual registration processes and movement permits for travel outside designated areas, reflecting a governance approach that prioritises control alongside inclusion[39]. Until recently, refugees were excluded from major digital government platforms such as the e-Citizen portal, limiting access to services, payments, and formal economic participation.

These gaps become most visible at the point of service delivery, where access is shaped not only by policy, but by how individuals are perceived and categorised within institutions.

Box 3: When Access Depends on Perception

One time when I got sick, I went to the hospital and when they asked for my identification, I showed my passport and the asylum seeker's pass. I was not asked for extra money to receive treatment since they referred to me as "Mzungu", "a white person". I got my services well and got my prescription which I went to buy at a nearby pharmacy. When I got to the pharmacy, I noticed the medicine had a higher amount since I had bought panadol earlier and already knew the price. I immediately told the pharmacist that I knew the right amount of the medicine and they now sold to me with the right amount[40].
~ Afghan asylum seeker

Although national frameworks promote inclusion, frontline implementation frequently diverges from formal commitments. Health workers are rarely trained on refugee entitlements and often continue to perceive refugees as humanitarian beneficiaries rather than rights-holders within the public system. Interviewees described repeated cases in which refugees were charged additional "foreigner" fees despite the absence of formal policy requiring such payments. In practice, county-level discretion often overrides national commitments, producing uneven experiences of care across facilities and locations.

Decentralisation reinforces these inconsistencies. County governments retain significant control over healthcare delivery, yet guidance on refugee inclusion remains limited and unevenly applied. As a result, access frequently depends on local interpretation rather than nationally guaranteed protections.

At the same time, the sustainability of refugee healthcare is increasingly uncertain. Humanitarian organisations continue to fill major gaps in service delivery, particularly in camp settings, yet international funding reductions are already disrupting programmes that many refugees rely upon. In Kakuma and Dadaab, health workers described reductions in nutrition support and community outreach programmes despite rising demand linked to drought, displacement, and food insecurity[41].

In Kenya, access to healthcare is not only about reaching a clinic, but about being recognised by the system once you get there

This exposes a deeper structural tension. While policy frameworks increasingly support inclusion and universal healthcare, the systems responsible for delivering care remain heavily dependent on unstable humanitarian financing. Access therefore becomes vulnerable not only to climate shocks, but also to fluctuations in donor support and institutional capacity.

Despite these constraints, there are emerging examples of more inclusive approaches. Kenya's National Climate Change and Health Strategy (2024–2029) reflects growing recognition that climate resilience must be integrated into healthcare planning[42]. At the local level, the Kalobeyei Integrated Social and Economic Development Programme (KISEDP) has piloted refugee inclusion within the Social Health Insurance Fund (SHIF)[43]. Refugee interviewees reported that newer identification processes linked to the Social Health Authority reduced discriminatory treatment by making refugee status less immediately visible during healthcare registration[44].

Community health volunteers and refugee-led organisations also continue to play a bridging role, particularly within Nairobi's informal settlements, where they provide referrals, health information, and navigation support to populations moving through complex administrative systems.

These developments demonstrate that more inclusive systems are possible, but they remain uneven, localised, and dependent on humanitarian and pilot-based interventions. As climate pressures intensify, the gap between formal inclusion and practical access is becoming increasingly difficult to sustain. In effect, healthcare access for refugees in Kenya remains partially outsourced, with inclusion mediated through humanitarian systems rather than fully embedded within national institutional frameworks.

South Africa: Discretion and Urban Absorption

In South Africa, healthcare access is shaped less through formal systems of recognition and more through discretion at the point of service. Unlike Kenya's camp-based refugee model, migrants and asylum seekers are absorbed into cities, informal settlements, and townships, where they navigate overcrowded public systems already under significant strain. Climate stress intensifies these pressures. Floods, heatwaves, infrastructure failures, and regional livelihood disruptions are increasing both health risks and mobility, while public institutions struggle to respond consistently. Under these conditions, legal entitlement alone does not guarantee access to care. Instead, access is shaped by how individuals are identified, interpreted, and treated within overstretched urban systems.

Climate Pressure and Urban Health Systems

In South Africa, climate pressure, mobility, and healthcare strain increasingly converge within the same urban spaces. Migrants and asylum seekers are largely absorbed into cities, informal settlements, and peri-urban townships, where they rely on public systems already operating under pressure. Fieldwork in Johannesburg and Durban showed that climate-related disruptions are intensifying health risks in areas where overcrowding, poor infrastructure, and uneven access to services already shape everyday life[45].

Over the years, South Africa has experienced increasingly severe floods, droughts, storms, and wildfires. The 2022 KwaZulu-Natal floods alone displaced thousands, destroyed homes, damaged clinics, and disrupted water and sanitation infrastructure[46]. Interviewees in Durban described how flooding contaminated water sources and interrupted access to clinics and transport routes, particularly in informal settlements already facing poor

For many migrants, access to care is shaped less by the law than by how it is applied at the clinic

living conditions[47] .

Fieldwork showed that many migrants arriving in Johannesburg and Durban were moving within broader contexts of economic hardship, political instability, and environmental stress. Several interviewees described declining livelihood opportunities, drought, and flooding in their countries of origin as part of the pressures shaping their movement into South Africa[48]. These accounts indicate that environmental pressures increasingly intersect with broader drivers of regional mobility.

Unlike Kenya's camp-based refugee model, South Africa absorbs migration directly into ordinary urban systems. Migrants queue in the same overcrowded clinics, live in the same flood-prone settlements, and depend on the same strained public infrastructure as low-income South Africans. Most migrants interviewed were living in overcrowded neighbourhoods and informal settlements where climate exposure and health risks intersect sharply. Approximately 24% of South Africa's urban population lives in informal settlements[49]. In Durban, residents described repeated flooding washing sewage into living areas. In Johannesburg, migrants living in inner-city buildings described poor ventilation, blocked drainage systems, and recurring respiratory illness linked to deteriorating housing conditions[50].

These pressures are absorbed by a public healthcare system that was already strained before climate shocks intensified demand. South Africa's system remains deeply unequal, divided between an under-resourced public sector and a private system serving a smaller, wealthier population[51].

Approximately, 80% of the population depends on public healthcare facilities[52], many of which face overcrowding, staff shortages, medicine stock-outs, and deteriorating infrastructure.

Health workers in Gauteng and KwaZulu-Natal described clinics struggling to maintain routine services during flooding, electricity disruptions, and extreme heat. During a 2023 heatwave in Johannesburg, queues extended beyond available shelter, with patients fainting while waiting for water and shade[53]. Facilities reported interruptions to routine care during flood-related infrastructure damage and transport disruptions. Health workers also described patients arriving late after walking long distances when taxi routes became inaccessible, while some clinics struggled to maintain refrigeration for medication during electricity disruptions. Climate-related events were repeatedly described as exposing weaknesses already visible within overstretched public facilities[53].

Migrants experienced these pressures differently. Because most lacked access to private medical insurance, they depended almost entirely on public healthcare facilities. Health workers noted that migrant patients often arrived in more severe condition because care-seeking was delayed by transport costs, documentation concerns, fear of mistreatment, or previous negative experiences.

In South Africa, access to healthcare is not denied outright but varies across facilities, producing uneven outcomes for migrants seeking care

Box 4. Delaying care until it becomes an emergency

I started feeling sick after the floods because the water entered our room and everything became damp. I was coughing badly, but I delayed going to the clinic because I feared being asked for documents again. The taxis were also not operating properly after the rains. By the time I finally went to the hospital, I could barely breathe and had to be admitted immediately[54].
~ Zimbabwean migrant, Durban

Facilities serving migrant-dense urban areas reported recurring increases in climate-related illness. Clinics in Johannesburg described seasonal spikes in respiratory infections, while facilities in Durban reported increases in diarrhoeal illness following flooding. Health workers linked these patterns to overcrowded housing, poor sanitation, and environmental exposure[55].

Public health funding remains tied to static population estimates, leaving limited flexibility to respond to changing demand or population movement. Clinics in migrant-dense areas were therefore expected to absorb rising patient numbers, climate-related disruptions, and fluctuating mobility without corresponding increases in staffing, infrastructure, or operational funding. As one clinic manager in Gauteng explained, "We don't have a specific budget for migrants; we just treat whatever comes, but we can't provide extras like translators or transportation."[56] Interviewees also noted that public health programmes are not designed around mobility. Migrants are frequently missed during vaccination campaigns and outreach efforts because interventions are organised around formally documented populations.

Floods and storms further disrupt service delivery by damaging clinics, interrupting electricity supply, and limiting transport access. Following the 2022 KwaZulu-Natal floods, repair costs to health infrastructure were estimated at approximately R1 billion (~£50 million)[57]. Emergency repairs often diverted resources from longer-term system improvements. Clinics and hospitals are increasingly expected to absorb climate-related disruption and rising mobility without the infrastructure, planning systems, or operational flexibility required to respond consistently. These findings suggest that informal urban settlements are becoming primary sites where climate stress, mobility, and health system pressure converge.

When rights do not translate into access

South Africa's legal framework formally guarantees broad healthcare access, yet fieldwork in Johannesburg and Durban revealed a persistent gap between legal entitlement and everyday experience. Section 27 of the Constitution guarantees access to healthcare services for "everyone," while the Refugee Act affirms that refugees are entitled to the same health rights as citizens[58]. Department of Health directives further state that asylum seekers, regardless of documentation status, should receive free primary healthcare and access to essential treatment, including antiretroviral therapy.

In practice, however, access was often uncertain and uneven. Healthcare experiences depended heavily on the attitudes of frontline staff and institutional routines. Some health workers acknowledged what interviewees described as "medical xenophobia," where migrants experienced delays, hostility, or selective enforcement of documentation requirements[59]. Interviewees recounted being pushed to the back of queues, ignored during registration, or asked for identification in ways local patients were not. A Zimbabwean mother described being turned away from antenatal care after being asked to produce a passport she did not have. Evidence from Gauteng similarly found that migrant youth reported lower satisfaction with healthcare services and, in some cases, outright denial of care[60] .

Access was therefore shaped not only by law, but by how it was interpreted and applied. While national legislation requires facilities to provide care, the Immigration Act permits the reporting of undocumented migrants[61], creating uncertainty within healthcare settings. Some frontline workers interpreted documentation checks as part of their institutional responsibility, even where this conflicted with public health policy. Interviewees described situations in which documentation status determined whether treatment was delayed, charged for, or denied entirely. In one KwaZulu-Natal hospital, foreign patients were reportedly asked to pay deposits for non-emergency treatment despite this contradicting national policy[62].

Box 5: When Rights Depend on the Person Behind the Desk

I once went to a clinic with severe stomach pain and the nurse asked for my passport before even checking me. When I explained that my permit had expired while waiting for renewal, she told me to sit aside. Another nurse later called me quietly and said I could still be helped. The treatment I received depended entirely on who was sitting behind the desk that day[63].
~ Congolese asylum seeker, Johannesburg

Administrative uncertainty deepened these barriers. Persistent backlogs within the Department of Home Affairs left many asylum seekers and migrants in prolonged states of legal limbo, relying on temporary or expired permits. This had direct consequences for healthcare access. Many interviewees described avoiding clinics altogether due to fear of exposure to immigration enforcement or humiliation during registration processes. Others relied on churches, migrant community groups, or informal networks to identify which facilities were safer to approach, what documents to carry, and when to seek care to minimise confrontation.

Digitalisation is beginning to reinforce these exclusions. South Africa's transition toward digital health records and the National Health Insurance (NHI) framework increasingly relies on systems linked to national identification numbers or barcoded permits. At one Johannesburg hospital, a pilot registration system required patients to create digital profiles using national identification documents, forcing many refugees and asylum seekers back into slower paper-based processes.

The 2023 NHI Act further narrows guaranteed access for asylum seekers and undocumented migrants primarily to emergency services and communicable diseases[64], raising concerns about future access to chronic and routine care.

Access was rarely denied uniformly, but applied unevenly across facilities, administrators, and frontline staff. Two patients with similar needs could experience entirely different outcomes depending on the clinic, the administrator, or the documentation they carried. Under growing urban and climate pressure, access increasingly depended not only on legal entitlement, but on how individuals were processed and treated within overstretched frontline institutions. Similar patterns were observed across facilities and locations, indicating that these outcomes reflect systemic dynamics rather than individual or isolated practices.

Fragmented systems and informal resilience

The uneven access observed across Johannesburg and Durban reflects deeper fragmentation within South Africa's governance system. Responsibilities for migration, healthcare, and disaster response are distributed across institutions that often operate with limited coordination, producing gaps between national policy and everyday implementation.

Migration governance falls primarily under the Department of Home Affairs, while healthcare is administered through the Department of Health and implemented provincially. Climate-related emergencies are managed through separate disaster response structures. In practice, these systems operate alongside one another rather than in coordination, leading to uneven application across provinces, municipalities, and healthcare facilities.

A clear example emerged in Gauteng in 2020, when a provincial directive excluded non-nationals, including children, from free healthcare despite national legal protections[65]. Although later overturned, interviewees reported that exclusionary practices continued informally within some facilities. Similar inconsistencies appeared across field sites, particularly around documentation requirements, payment demands, and access to routine care.

Climate-related disruptions make these coordination gaps more visible. During the COVID-19 pandemic, vaccination campaigns were largely organised around formally registered populations, leaving many undocumented migrants outside outreach systems. Several interviewees described learning about vaccination drives only after they had taken place, particularly in migrant-dense settlements where outreach was limited[66] .

Funding pressures reinforce these tensions. Provinces hosting large migrant populations, including Gauteng and KwaZulu-Natal, already operate under significant fiscal strain. Health advocates described cases where migrants were informally treated as external to the populations public systems were funded to serve, shaping how some facilities interpreted entitlement and prioritised limited resources.

At the same time, some of the most consistent forms of support emerged outside formal institutions. Civil society organisations, faith-based networks, and migrant-led groups frequently acted as intermediaries between migrants and the healthcare system. Organisations such as the Scalabrini Centre assisted migrants with referrals, interpretation, legal guidance, and navigating healthcare procedures[67]. Migrants also described relying heavily on peer networks for transport, translation, childcare, and information about which clinics were

more accessible or less hostile. In some cases, WhatsApp groups were used to share information about which facilities were more accommodating and where treatment could be obtained without extensive documentation checks.

Localised efforts to improve inclusion were also visible within parts of the healthcare system. Some clinics displayed multilingual signage informing patients of their right to emergency treatment, while mobile health initiatives in migrant-dense communities provided HIV testing and referrals without requiring formal identification. Much of the system's ability to absorb mobility therefore depends on informal adaptation, local discretion, and external support rather than consistent institutional integration within the public healthcare system.

What the comparison reveals

The comparison between Kenya and South Africa shows that similar patterns of exclusion can emerge through fundamentally different governance arrangements. In both countries, healthcare systems do not only deliver care; they organise access by determining who is recognised, how rules are applied, and which populations are incorporated into service delivery systems. Climate stress does not create these dynamics, but exposes and intensifies them by placing greater pressure on already uneven systems. While elements of administrative exclusion are also present in South Africa, and forms of discretion exist within Kenya's system, the dominant patterns observed differ in how access is structured and applied across the two contexts.

In Kenya, access is shaped primarily through recognition. Refugees and asylum seekers must be visible within administrative and service delivery systems in order to access healthcare, insurance, and public services.

The central challenge is therefore bureaucratic. Access depends on documentation, registration, insurance enrolment, and interoperability between state systems. Individuals who are not fully recognised within these structures remain excluded regardless of medical need. Although Kenya has adopted increasingly progressive policy frameworks, including the Refugee Act and the Shirika Plan, implementation remains uneven because administrative systems continue to operate in parallel rather than in coordination.

South Africa produces a different form of exclusion. Migrants and asylum seekers are formally incorporated into the general public healthcare system rather than managed through separate humanitarian structures. In principle, this creates a more unified model of inclusion. In practice, however, access is shaped heavily through frontline discretion. Legal entitlement exists, but its application varies across facilities, provinces, and individual healthcare workers. Documentation checks, institutional attitudes, fear of immigration enforcement, and inconsistent implementation all shape whether care is delayed, denied, or made accessible. In Kenya, exclusion is largely produced through systems of recognition; in South Africa, it emerges through systems of application. One determines access through visibility within administrative systems, the other through how rights are interpreted and enforced in practice.

Despite these differences, both systems produce similar outcomes. Migrants and refugees in both countries often occupy a grey zone between formal inclusion and practical access.

Many migrants delay seeking care due to fear of costs, documentation checks, or mistreatment, arriving only when conditions have already worsened significantly.

Fieldwork across Nairobi, Johannesburg, Durban, Kakuma, and Dadaab consistently showed that migrants and refugees face higher health risks while encountering greater barriers to care[68]. In both contexts, they are concentrated in informal settlements and low-income urban areas where climate-related exposure is highest and healthcare access is already uneven. Flooding in informal settlements disrupted access to clinics and basic services in both Nairobi and Durban, while overcrowding, poor sanitation, and insecure housing intensified exposure to respiratory and waterborne illness.

The comparison also reveals a persistent disconnect between climate adaptation, migration governance, and public health planning. In both countries, health systems continue to operate largely around fixed and citizen-centred populations, while climate stress is increasing mobility, urban vulnerability, and fluctuating demand for healthcare. Kenya has begun to address this gap through its national climate and health strategy, which recognises the need for greater coordination[69]. In South Africa, climate governance remains concentrated largely within environmental and infrastructure sectors, with limited integration into migration or health planning. In both cases, responses remain largely reactive, focusing on emergency relief after climate shocks rather than adapting systems to changing patterns of mobility and vulnerability.

These gaps are likely to deepen as climate pressures intensify. More frequent floods, droughts, and extreme heat are expected to place additional strain on already overstretched health systems, particularly in rapidly growing urban areas. At the same time, economic instability, environmental stress, and regional inequalities are likely to continue shaping mobility across Eastern and Southern Africa.

Current policy frameworks, including commitments to universal health coverage and the Sustainable Development Goals, assume inclusive systems, yet the mechanisms required to operationalise inclusion remain weak or unevenly applied.

The comparison ultimately shows that exclusion is not accidental or peripheral to how health systems function under pressure. In Kenya, exclusion is produced through systems that determine who is recognised within administrative and service delivery structures. In South Africa, exclusion emerges through systems that determine how rights are interpreted and applied in practice. Climate stress intensifies both, exposing the limits of healthcare systems that continue to organise access unevenly under conditions of increasing mobility and environmental disruption.

Policy Recommendations

Kenya: Moving from Parallel Systems to Public Inclusion

Kenya's primary challenge is no longer the absence of policy, but the continued separation between refugee governance systems and national service delivery. Refugees remain partially visible within humanitarian structures while remaining inconsistently recognised within public systems. The priority is therefore to move from parallel service delivery toward full institutional inclusion. The recommendations that follow are derived directly from the patterns observed across both case studies, particularly the role of administrative recognition and frontline discretion in shaping access to care.

- Integrate refugee registration systems with national health, insurance, and digital platforms so that refugee identification is recognised consistently across public services.
- Expand Social Health Insurance Fund (SHIF) enrolment beyond pilot programmes and ensure refugees can access healthcare across counties without informal fees or inconsistent administrative requirements.

- Shift refugee healthcare progressively from humanitarian dependency toward sustained inclusion within national and county health systems, supported through public financing rather than parallel NGO-led structures.

- Incorporate mobility directly into climate and health planning by prioritising refugee-hosting counties within climate-health strategies and investing in resilient healthcare infrastructure, water systems, and supply chains in high-risk areas

South Africa: Reducing Discretion in Healthcare Access

South Africa's challenge lies less in formal entitlement than in uneven implementation. Healthcare access is often shaped by frontline discretion, documentation uncertainty, and inconsistent institutional practice. The priority is therefore to reduce variability in how rights are applied across the healthcare system.

- Enforce binding national standards on migrant and asylum seeker access to healthcare across provinces and facilities, supported by clear accountability mechanisms and frontline guidance.

- Standardise administrative procedures across healthcare facilities, including the recognition of temporary and alternative forms of identification, to reduce arbitrary denial of care.

- Ensure migrants and asylum seekers are incorporated into National Health Insurance planning, vaccination campaigns, and routine public health outreach rather than treated as external to population planning

- Improve coordination between health, migration, and disaster-response institutions so that climate-related emergencies do not further exclude mobile populations

Shared Priorities: Building health systems that can absorb mobility

The findings from both countries point to a broader structural problem: health systems continue to operate around fixed and citizen-centred populations while climate stress is increasing mobility, urban vulnerability, and fluctuating healthcare demand. Expanding healthcare access therefore requires more than additional services; it requires systems capable of responding to movement.

- Plan healthcare delivery, infrastructure, and financing around population mobility rather than static population estimates, particularly in informal settlements and high-risk urban areas.

- Strengthen data systems capable of capturing mobility-related health pressures and climate-related disruptions in real time to support more responsive planning.

- Support community-based health networks, including migrant-led initiatives and community health workers, which already play a critical role in bridging gaps between vulnerable populations and formal healthcare systems.

- Align climate adaptation, migration governance, and public health planning through integrated policy frameworks that recognise cross-border and internal mobility as part of future health system planning rather than as an external issue.

Conclusion

Climate pressure is exposing a growing mismatch between how healthcare systems are organised and the realities they are increasingly required to manage. Across both Kenya and South Africa, public institutions are responding to rising mobility, urban vulnerability, and environmental disruption through systems still largely structured around fixed and formally recognised populations. The result is that access becomes uneven precisely where vulnerability is most concentrated.

The comparison between the two countries shows that exclusion does not emerge in a single form. In some contexts, it is produced through administrative systems that determine who becomes visible within public institutions. In others, it emerges through inconsistent implementation at the point of service. Yet both pathways produce similar outcomes: delayed care, uncertainty, and unequal access under conditions of rising pressure.

What is increasingly at stake is not only the capacity of health systems, but their ability to adapt to changing patterns of mobility and vulnerability. Climate-related disruption is already reshaping how people move, where pressures concentrate, and how demand for healthcare emerges within cities and informal settlements. Systems that continue to treat mobility as temporary, exceptional, or external are likely to face growing strain as these pressures intensify.

The challenge ahead is therefore institutional as much as humanitarian. Responding effectively will require health, climate, and migration governance to move beyond parallel approaches and towards systems capable of absorbing mobility as part of everyday public planning rather than as a crisis to be managed after the fact.

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POLICY REPORT

Who Governs AI in South Africa? Coordination and Accountability in Digital Governance

Dr. Olga Ustyuzhantseva

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POLICY BRIEF

When Diplomacy Goes Viral: How Digital Pressure Shapes Foreign Policy Decision-making in Africa

Digital platforms are reshaping how diplomacy is conducted. This brief examines how real-time mobilisation compresses negotiation timelines, disrupts institutional sequencing, and redistributes authority across state and non-state actors. Drawing on cases from Kenya and South Africa, it argues that viral diplomacy is not episodic, but a structural condition requiring adaptation in how foreign policy is coordinated, communicated, and sustained.

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KONRAD ADENAUER STIFTUNG

POLICY BRIEF

Who moves, who stays, and who decides?
Shifting mobility corridors in the East and Horn of Africa

As displacement and migration intensify across the East and Horn of Africa, mobility is becoming a defining feature of governance and development. This policy brief explores emerging corridors of mobility, highlighting their implications for security, urban planning and regional cooperation, and offering evidence-based insights for anticipatory, coordinated policy responses

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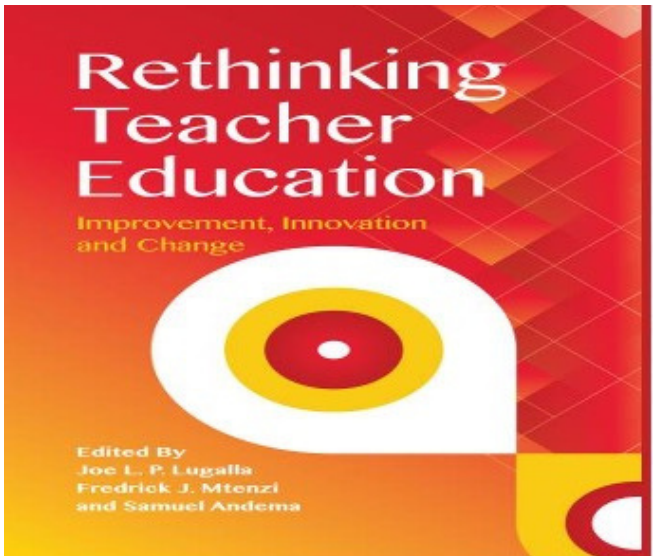

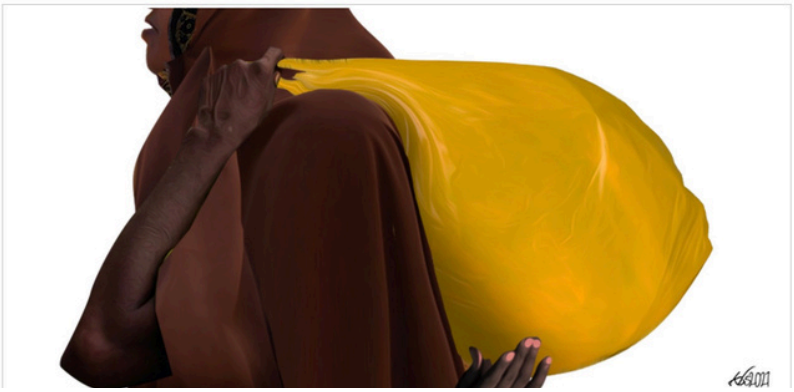

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OLAM Africa Research Institute is an independent, Africa-rooted policy think tank advancing Transition Intelligence for an Africa in transition. Through evidence, insight and foresight, we help African institutions anticipate change, govern emerging realities and adapt effectively. Our work focuses on mobility, climate and digital governance—areas where some of the continent's most significant governance transitions are unfolding.

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