MULTI-SECTOR NEEDS ASSESSMENT (MSNA)

DADAAB REFUGEE CAMP | KENYA

OCTOBER 2022

CONTEXT

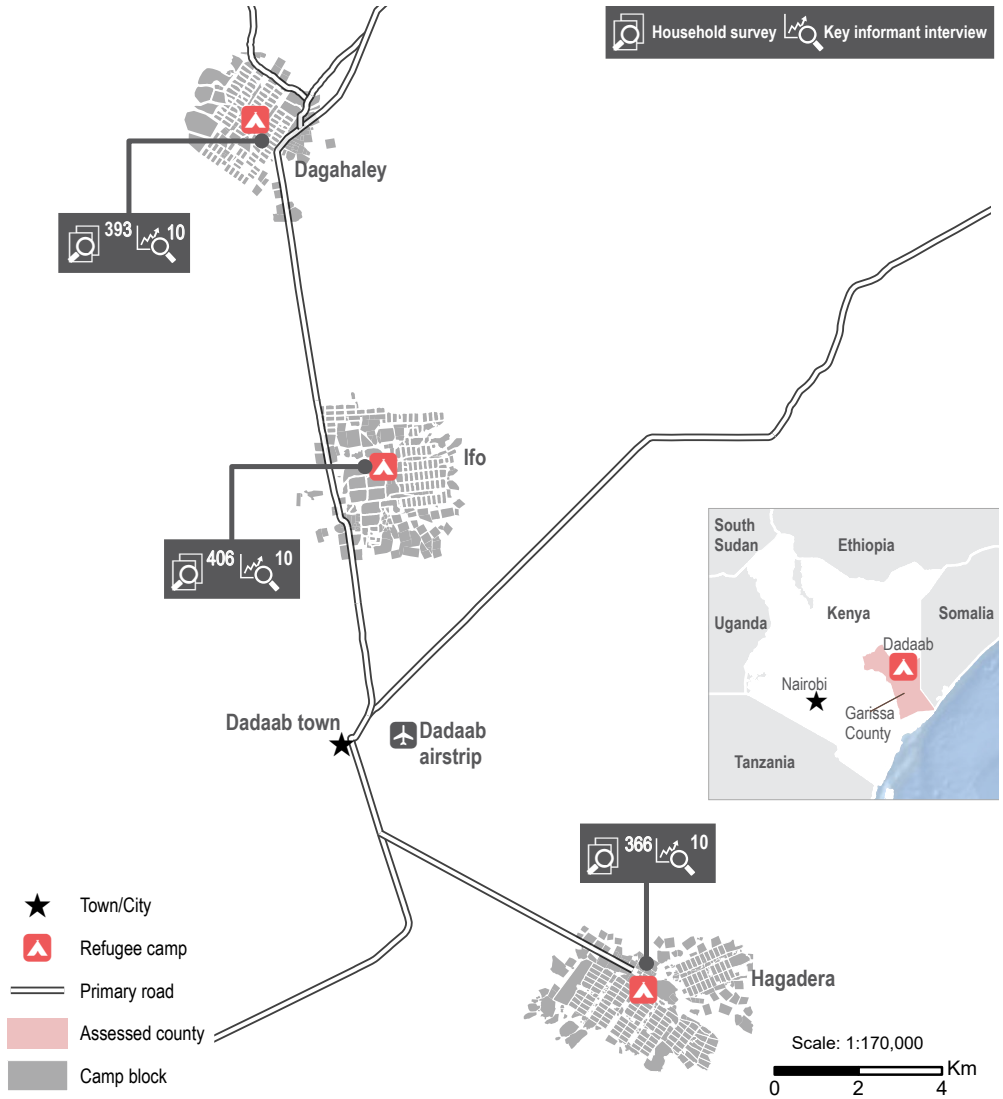
As of October 2022, a total of 233,726 refugees and asylum seekers resided in Dadaab Refugee Complex (Dagahaley, Hagadera and Ifo refugee camps). According to the MSNA conducted by REACH in Dadaab in 2021, these refugees and asylum seekers were found to have various needs such as food assistance, shelter, health and nutrition services, among others. In addition, projections by Famine Early Warning Systems Network (FEWS NET) on the food security outlook for June to September 2022, suggested potential constraint on household (HH) food availability and income across northern pastoral Kenya, due to below-average March to May long rains. Furthermore, according to the Integrated Food Security Phase Classification (IPC) Acute Food Insecurity Situation in July to September 2022, about 3.5 million people (24% of the Arid and Semi-Arid Lands' population) were facing high levels of acute food insecurity – IPC Phase 3 or above, with about 2.7 million people in IPC Phase 3 (crisis) and 785,000 people in IPC Phase 4 (Emergency). Moreover, due to the ongoing drought and continuing conflict in Somalia, the Dadaab refugee camps are experiencing an influx of new arrivals[1]. The United Nations High Commissioner for Refugees (UNHCR) estimates that approximately 2,100 people are reaching Dadaab every week and projects the number to be 121,300 individuals by April 2023[1]. The increasing number of new arrivals may potentially put pressure on the available resources and access to humanitarian assistance for the refugee community.

In light of the above needs, REACH in close coordination with the Norwegian Refugee Council (NRC) and UNHCR, conducted the 2022 MSNA in Dadaab refugee camps. The assessment sought to understand humanitarian needs of refugees and asylum seekers and undertake a comparative analysis of the outcomes with previous rounds of MSNAs. Findings from this assessment will help humanitarian actors within Dadaab to plan for and execute a harmonized and evidence-based humanitarian response.

This situation overview presents findings of the MSNA conducted in October 2022. Similar assessments were conducted in November 2021, October 2020, September 2019, February 2019 and December 2018 across the three camps. It provides an analysis of needs across the following sectors; food security and livelihoods, water, sanitation and hygiene (WASH), protection, health and nutrition, and education. Furthermore, it provides a trend analysis of some key indicators over the period from November 2021 to October 2022.

1. Kenya - New influx of refugees (DG ECHO, UNHCR) (ECHO Daily Flash of 4 November 2022, press release.

LOCATIONS OF DATA COLLECTION



Funded by European Union Humanitarian Aid

NRC NORWEGIAN REFUGEE COUNCIL

REACH Informing more effective humanitarian action

METHODOLOGY

A total of 1,165 HH level interviews and 25 KIIs with leaders of various groups in the three camps, were conducted between 11 and 21 October 2022. (See table 1 and table 2 for sample breakdown).

The sample for HH interviews was selected through probability random sampling at individual camp level to fulfill a 95% confidence level and 5% margin of error and was calculated based on the HH population of each camp. The confidence level is guaranteed for all questions that apply to the entire surveyed population of each camp. Findings relating to a subset of the surveyed population may have a wider margin of error and a lower confidence level.

The data was weighted during analysis to account for lack of proportionality for individual camp samples. The data was aggregated at the overall Dadaab camp level to fulfill a 95% confidence level and 5% margin of error. Findings represent October 2022 findings unless otherwise specified. More information about the methodology used for this assessment is found in the terms of reference.

Table 1: HHs sample

	Dagahaley	Hagadera	Ifo	Total
Population size (of HHs)	15,718	16,536	14,508	**46,762**
Sample size	393	366	406	**1,165**

Table 2: KIs sample

Community leader group	Dagahaley	Hagadera	Ifo	Total
Camp leaders	3	2	2	6
Youth leaders	2	2	2	6
Leaders of persons with disabilities	1	1	1	3
Minority group leaders	2	1	1	4
Leaders of older persons	2	1	2	6
Total	**10**	**7**	**8**	**25**

KEY FINDINGS

- Despite an overall reduction in food consumption gaps (42% of HHs down from 59% in November 2021, were found to have either **a poor or borderline food consumption score**), findings suggest that HHs in Dadaab are increasingly engaging in severe food consumption coping strategies in order to meet their daily needs. The majority of HHs (72% up from 54% in November 2021) were found to be using negative livelihood-based coping strategies (stress, crisis or emergency). This suggests that the food security situation in such HHs would likely have been worse were they not engaging in these unsustainable coping strategies.
- Community members who were not registered as refugees or asylum seekers reportedly encountered challenges in **accessing essential services.** The proportion of HHs that reported having some or all of their members who were unregistered increased slightly from 20% in the previous MSNA to 22%, likely due to the additional HH members who arrived in the camps between the year 2021 and 2022. Among these, a high proportion (76%) reportedly encountered challenges in accessing food assistance, in addition to other essential services like resettlement and employment opportunities. Furthermore, the majority of KIs (18/25) reported that undocumented community members lacked access to basic services, suggesting that **a lack of documentation served as a barrier** to those in need of essential services.
- Whilst the majority of HHs (84%) perceived having positive relations with the host community, challenges persist with ongoing competition for humanitarian assistance, livelihoods and disputes over land and shelter. Particularly, 8% of HHs reported having poor or very poor relations with the host community, with **all HHs in Dagahaley reporting competition for food assistance** and **work** to be the reasons for the strained relations. Moreover, all KIs in Dagahaley (10/10) and Hagadera (7/7) reported that community members were involved in land and shelter conflicts within the camp or between members of different camps and the host community. This suggests that some community members were competing over humanitarian assistance and other resources, thus potentially damaging relations with the host community.
- HHs in Dadaab are reportedly struggling to obtain enough water for their day to day needs with a majority needing to engage in time consuming WASH coping mechanisms which takes time from essential daily tasks. Thirty-one (31%) of HHs reported not having access to adequate water to meet their HH's needs in the 30 days prior to data collection. Among these, 56% and 48% reportedly **fetched water at another water-point further way** or **reduced the consumption of water for hygiene practices,** respectively. This suggests that HH members spend up time meant for other vital activities while fetching water at far water-points.

Funded by European Union Humanitarian Aid
NRC NORWEGIAN REFUGEE COUNCIL
REACH Informing more effective humanitarian action

- Despite the majority of HHs (94%) reporting having access to latrines or toilets, there were reported difficulties in accessing adequate sanitation facilities. The majority 21/25, 20/25 and 18/25 of KIs reported that **latrines were crowded, lacked privacy** (not segregated by gender), or **the cesspits were full** respectively. A lack of adequate sanitation facilities can potentially lead to poor waste disposal, thus exposing individuals to the risk of infection, in the event of a disease outbreak.
- Community members reportedly experienced barriers in accessing healthcare, despite the majority of HHs being able to access a functioning health facility within a walking distance. The majority (81%) and 45% of HHs reported the **long waiting time** and **unavailability of specific treatment and/or medicine** to be barriers in accessing healthcare. This suggests that the healthcare facilities that are available in the camps could probably be overstretched.
- A lack of access to credit to scale up businesses and undocumented people experiencing movement restrictions served as barriers for the majority of business people in the camps. Over two-thirds (39%) of HHs reported having at least one member of their HH operating a business in Dadaab. Among these, more than half (52%) reported **lacking access to funds for restocking their businesses**. Furthermore, the majority (19/25) KIs reported **movement restrictions** to be a barrier among community members who operated businesses. These barriers potentially led to fewer livelihood opportunities as the proportion of HHs that reported having members who were self-employed decreased across all the camps.
- Parents and guardians in HHs with children of school-going age[2] that were not attending school perceived their children to be too young to attend school and feared that children could be exposed to violence on their way to school. Particularly, in over half (54%) of HHs with school-going children who were not attending school, parents and guardians preferred their children to **attend Madrassa[3] classes first**.

DEMOGRAPHICS

The population pyramid in figure1 shows the aggregated demographics for all the three camps. The results indicate that **Dadaab's population pyramid is skewed towards the younger segments of the population** with a minority of HH members aged 60 or older.

The average household was found to consist of six members.

2. School-aged children are children between 4 and 17 years old.

3. Madrassa classes offer basic knowledge in Islamic education such as recitation of Quran, Seera etc.

Figure 1: Proportion of HH members by age and gender:

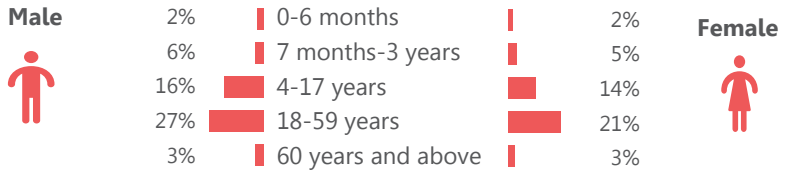
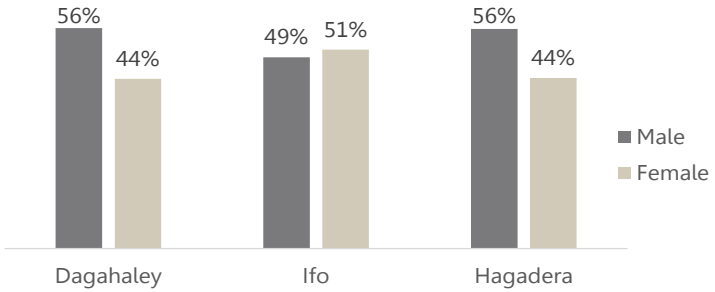
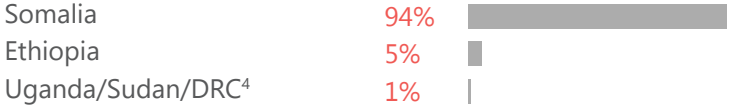


Figure 2: Gender of head of HH:



Overall, 3% of HHs reported receiving additional HH members since the year 2021, with almost all (98%) reportedly coming from Somalia. HHs commonly reported the fear of conflict (52%) and drought (36%) as reasons why new members arrived in the camps.

Figure 3: Reported countries of origin of heads of HHs:

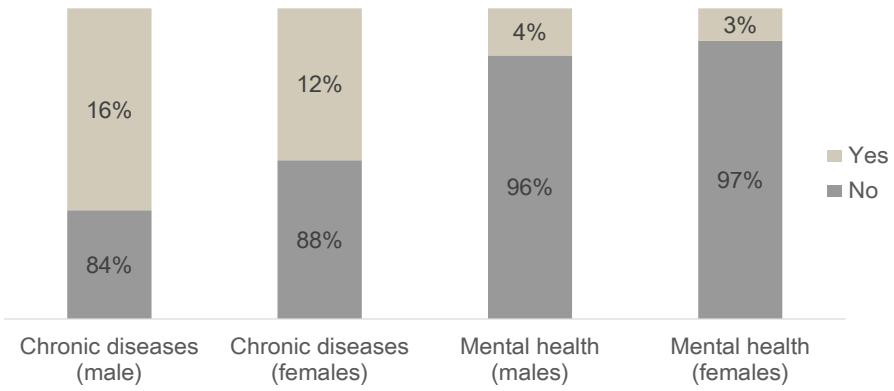


PERSONS WITH SPECIFIC NEEDS:

Eighteen percent (18%) of HHs reported having at least one member who had a specific need. In particular, persons with chronic medical conditions reportedly faced various challenges. The majority (22/25) and 14/25 of KIs perceived that persons with chronic medical conditions **lacked proper medication** and **money to cover for basic services** such as education, health or shelter, respectively. Moreover, 14/38 KIs perceived that children with chronic medical conditions felt discriminated by other children at school and lacked money to cover for school-related costs, which **served as a barrier in accessing education.**

4. The Democratic Republic of Congo

Figure 7: % of HHs reporting having at least one of the following vulnerability[5] profiles among their HH members :



PROTECTION

REGISTRATION AND DOCUMENTATION

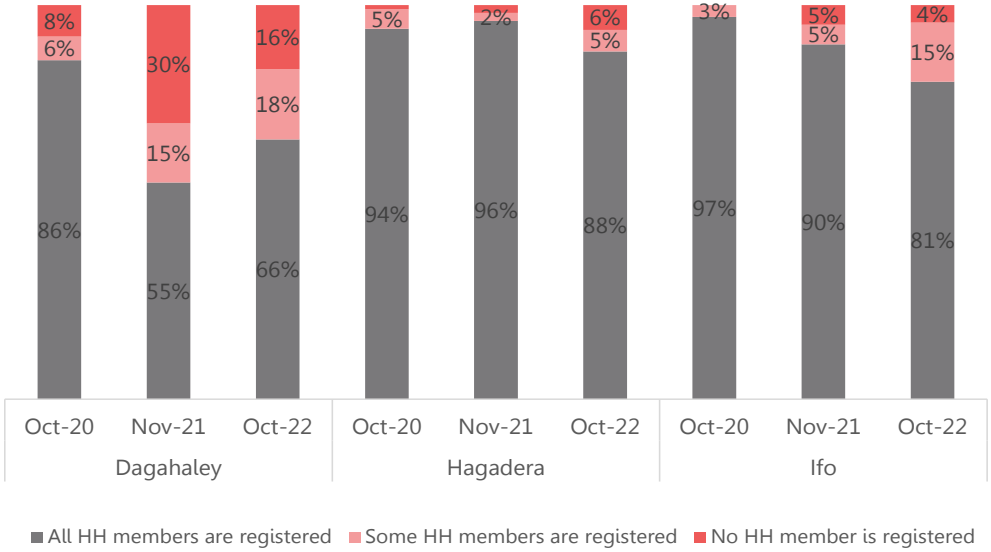
Unregistered community members reportedly lacked access to basic services. At the time of data collection, the majority of HHs (77%) and 20/25 KIs perceived that unregistered members did **not have access to food and humanitarian assistance,** respectively. In addition, the majority (16/25) KIs reported **a lack of documentation to register in schools as a barrier that undocumented children encountered in accessing education**.

Furthermore, the majority of KIs (21/25, 20/25 and 19/25) commonly perceived that community members who did not possess identification documents encountered **movement restrictions**, **could not access humanitarian aid,** and could not access **employment opportunities,** respectively.

Findings suggest that the proportion of HHs reporting some or all of their HH members **were not registered as refugees or asylum seekers seems to have increased slightly** (21% up from 19% in October 2021). This is probably because some (3%) HHs reported receiving additional members between the year 2021 and 2022. Furthermore, the majority of HHs (86%) reported that **all or some of their HH members who were unregistered had been in the country for less than 2 years**.

5. For more information on vulnerability profiles based on the Washington Group Guidance, please see here.

Figure 4: % of HHs per reported registration status, per round of the MSNA



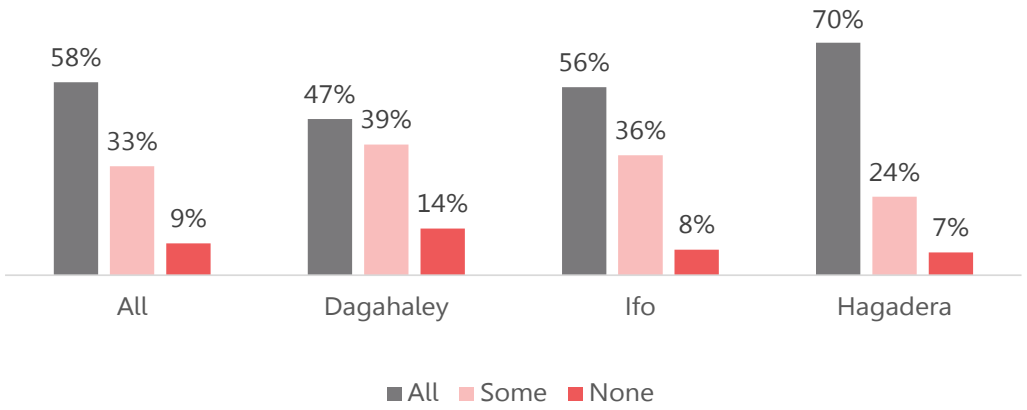
However, the proportion of HHs reporting that all HH members were not registered as refugees or asylum seekers in Dagahaley seems to have decreased by almost half (16% down from 30%) between November 2021 and October 2022.

The top reported reasons for HH members not registering were; **unavailability of registration** (35%) or **had applied for registration but had not yet received feedback on the status of their applicatio**n (25%).

Although the majority of HHs reported having members who possessed alien cards, a few HHs reported having members who were at risk of missing out on basic services due to lack of documentation. Ten-percent (10%) of HHs reported having members aged 18 years and older, who **did not possess alien cards issued by the government of Kenya**. Among these, almost half (49%) of HHs commonly reported that members had applied but not yet collected the alien cards, thus risked missing out on essential services due to a lack of alien cards.

Community members reportedly encountered barriers when applying for alien cards. Almost all (22/25) and 20/25 of KIs commonly reported the **long waiting period** between application and receiving the alien cards and **overcrowding in the service provider offices** as barriers that community members faced while applying for alien cards.

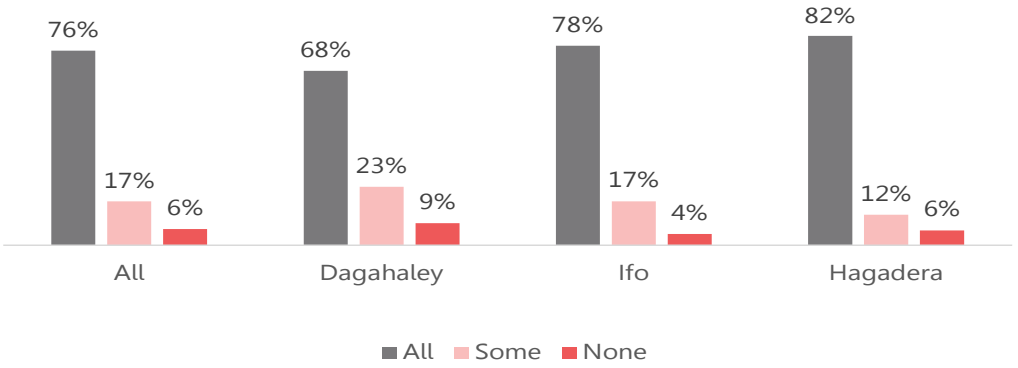
Figure 5: % of HHs with adults who possessed alien cards issued by the government of Kenya:



The majority (79%) of HHs reported that some or all their HH members were born in the refugee camps. Among these, **6% reported that none of their members possessed Kenyan birth certificates.**

The top reported reasons why HH members who were born in the camps lacked Kenyan birth certificates were; members had applied but not collected their certificates (57%), members did not know the process of applying for birth certificates (28%) or members experienced difficulties in accessing the humanitarian actors office for the registration (25%).

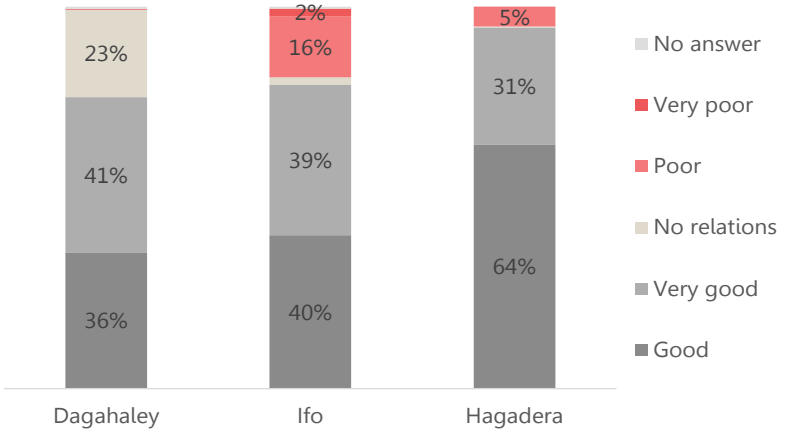
Figure 6: % of HHs with members who were born in the camps and reportedly possessed Kenyan birth certificates, among 79% of HHs:



SECURITY

Overall, the majority of HHs (96%) perceived the safety and security of their HHs to be good or very good in the six months prior to data collection. Even so, 4% perceived the safety and security of their HHs to be poor. Among these, 41% of HHs in Ifo reported experiencing **sexual and gender-based violence,** most likely when girls and women went to collect firewood. In addition, 40% of HHs in Dagahaley and Hagadera reported **verbal harassment by refugees** and **physical attacks by host community members** respectively. Verbal and physical harassment between refugees and the host community could have potentially been as a result of competition for food assistance and job opportunities, as all HHs in Dagahaley reported competition for food assistance to be the reason for poor relations with the host community.

Figure 8: Proportion of HHs by perception of the security situation in the six months prior to data collection



KIs also reported that women and girls experienced some form of physical or sexual harassment, most likely on their way to collect firewood. Most notably, 15/25 KIs and 14/25 of KIs reported that women aged 18 years and above and girls below 18 years reportedly experienced **physical harassment or violence,** respectively.

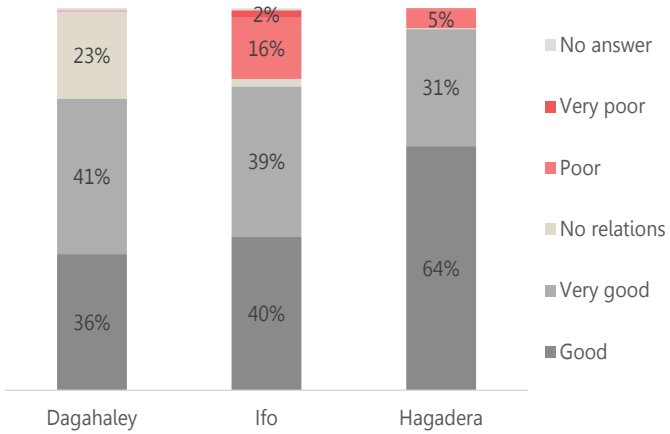
Whereas firewood was found to be the most common source of heat for cooking, over half of the KIs (13/25) and 43% of HHs reported that women and girls felt **unsafe while going to collect firewood**, as they feared being exposed to sexual or physical harassment.

The majority of HHs reportedly sought help from the **police** (86%) and **community leaders** (43%) when they experienced insecurity incidents. KIs reported that community members mostly reported security concerns to the police and community leaders, because these security personnel were perceived to be the **most trusted** (21/25 KIs) and **accessible** (9/25 KIs).

Among HHs that were found to have experienced security incidents, the majority **(88%) perceived that it took less than one month for security providers to resolve insecurity cases,** suggesting that insecurity cases were resolved promptly.

RELATIONS WITH THE HOST COMMUNITY:

Figure 9: Proportion of HHs by perception of relations with the host community:



Overall relations between the refugees and host community have remained positive, however challenges persist with ongoing competition for humanitarian assistance, livelihoods and disputes over land and shelter. Most notably, all HHs in Dagahaley reported **competition for food assistance** and **work** to be the reasons for poor relations with the host community. Furthermore, 63% of HHs in Hagadera reported the competition for natural resources including grazing land as a reason for poor relations with the host community.

Similarly, a higher proportion (18/25) of KIs reported that community members were involved in disputes within and/or between the camps, as well as the host community. **Land** and **shelter** disputes were the commonly reported disputes that community members were involved in, **indicating that community members were having conflicts over resources in the camps.**

FOOD SECURITY

Findings suggest that HHs in Dadaab refugee complex were **experiencing various levels of food consumption gaps,** with **42% of HHs found to have a borderline or poor food consumption score** (FCS). In addition, **38%, 9% and 24% of HHs were found to be using stress, crisis or emergency livelihood-based coping strategies** respectively, indicating that their food security situation would likely have been lower were they not engaging in these negative coping strategies. Moreover, **more than half (59%) of HHs were found to have a medium or low household dietary diversity score (HDDS)**, suggesting that their diets were likely suboptimal and non-diversified.

The majority of HHs were found to be commonly relying on humanitarian food assistance in order to meet their daily needs. The majority (79%) of HHs and 21/25 community leader KIs reported food assistance (voucher and in-kind) to be their most common source of food in the 6 months prior to data collection.

Despite food being the top priority need in most HHs, some HHs reported reduced quantities, quality and variety of food in their HHs. Almost all (24/25) KIs **reported food to be among their priority needs** at the time of data collection. However, about 28% of HHs perceived that the quantity, quality and variety of food in their HHs had decreased slightly or substantially in the 6 months prior to data collection. Among these, the majority (74%) attributed it to **high food prices** and **reduced food assistance** (28%).

FOOD CONSUMPTION SCORE (FCS)[6]:

The FCS is a composite score based on HHs' dietary diversity, food frequency, and relative nutritional importance of different food groups. It is calculated by inspecting how often HHs consume food items from the different food groups during a 7-day reference period. Only foods consumed in the home are counted in this indicator.

The FCS is used to classify HHs into three groups; those with a poor FCS, those with a borderline FCS, and those HHs with an acceptable FCS. A borderline FCS implies that HHs are consuming staples and vegetables everyday accompanied by oil and pulses a few times in week. On the other hand, a poor FCS implies that HHs are not consuming at least staple foods and vegetables on a daily basis, and rarely consumed protein rich foods, thus considered to have poor food consumption.

6: For more information on food security indicators (FCS,CSI, HDDS) please see here:

Findings suggest that **HHs with a poor FCS decreased by 26%, 18%, and 8% in Ifo, Dagahaley and Hagadera** respectively, between November 2021 and October 2022. This is likely due to the decrease in prices of food items by 10.3% in quarter 4 (October and December 2022) in Garissa county, according to the Joint Market Monitoring Initiative (JMMI) Q4 2022 report. Thus, more HHs were able to access varieties of food items and improved their food consumption.

Even so, 48% and 46% of HHs in Hagadera and Ifo were found to have borderline or poor FCS respectively, indicating that HHs were still experiencing food consumption gaps.

Figure 10: Proportion of HHs per FCS[6], per camp and per round of the MSNA

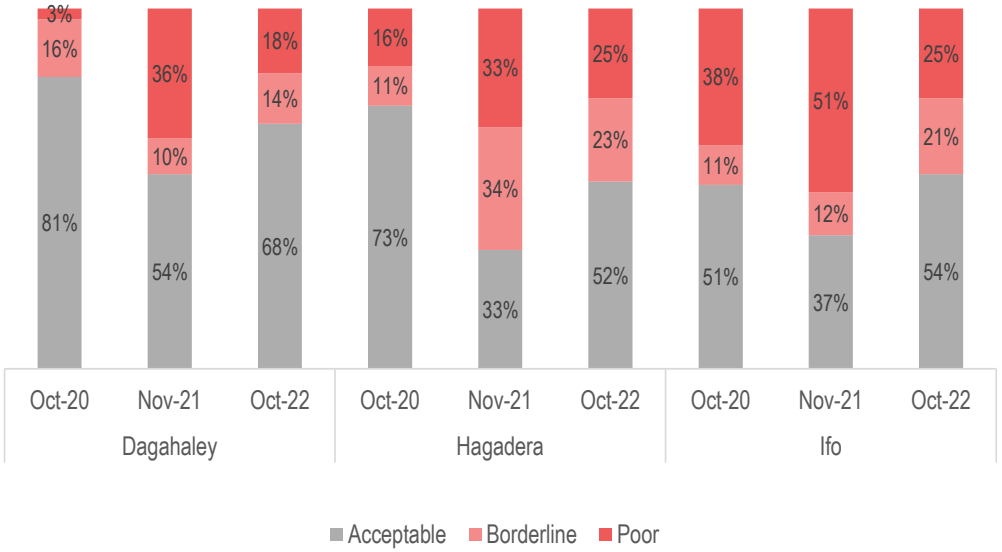


Table 3: Average number of days that HHs consumed various food groups in the seven days prior to data collection, per camp:[7]

Food group	Main Staples	Pulses	Meat/Fish/ Eggs	Milk	Vegetables	Fruits
Dagahaley	4	4	4	4	4	3
Hagadera	5	4	2	4	3	2
Ifo	5	4	3	4	4	3

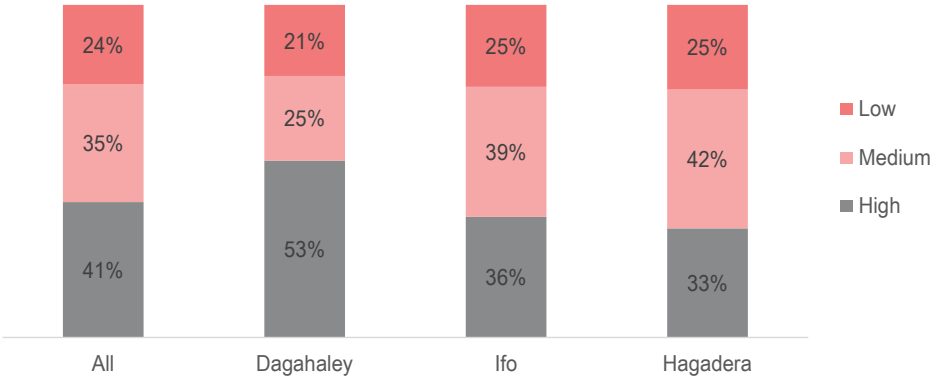
7: Kenya Joint Market Monitoring Initiative (JMMI) Q4 2022 report is found here .

HOUSEHOLD DIETARY DIVERSITY SCORE (HDDS)[6]:

HHs can be further classified as food insecure if their diet is non-diversified, unbalanced and unhealthy. The previous 24-hours' (before data collection) food intake of any member of the HH was used as a proxy to assess the dietary diversity of HHs. The HDDS is used to classify HHs into three groups: high, moderate or low dietary diversity. A high HDDS indicates food security, while moderate and low HDDS suggest moderate and more severe food insecurity respectively.

While some variation can be observed between the different camps (see Figure 11), **HHs in all locations were found to commonly have a low or medium HDDS, suggesting that their diets were likely suboptimal and non-diversified.** Overall, the proportion of assessed HHs that were found to have a low HDDS decreased by half (from 48% down to 24%) between November 2021 and October 2022.

Figure 11: Proportion of HHs per HDDS, per camp:

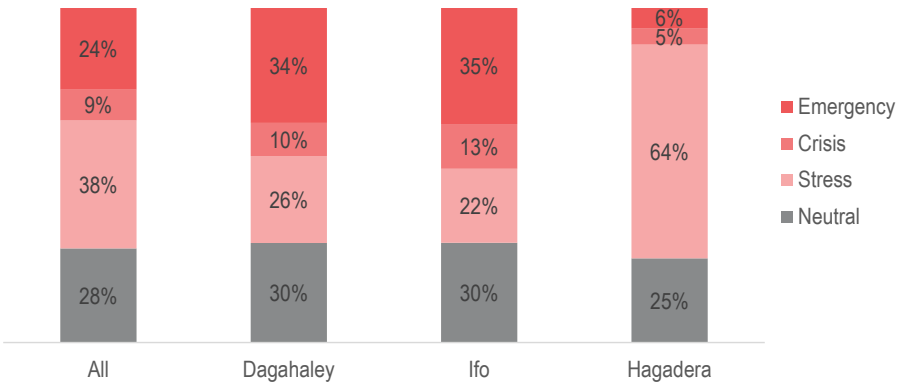


LIVELIHOOD COPING STRATEGY INDEX (LCSI)[6]:

The Coping Strategy Index (CSI) is an indicator of a HH's food security assessing the extent to which HHs use harmful coping strategies when they do not have enough food or enough money to buy food. The LCSI is used to classify HHs into four groups: HHs using emergency, crisis, stress or neutral coping strategies to cope with livelihood gaps, in the 30 days prior to data collection. The use of emergency, crisis, or stress-level livelihoods-based coping strategies typically reduces HHs' overall resilience and assets, in turn increasing the likelihood of food insecurity.

Overall, the majority of HHs (72%) in Dadaab refugee complex were found to be **using stress, crisis or emergency-level livelihood coping strategies to cope with lack of sufficient food**. This indicates that **HHs have been experiencing gaps in their ability to meet basic needs** in the 30 days prior to data collection.

Figure 12: Proportion of HHs per LCS[6] score, per camp in the 30 days prior to data collection:



Despite Hagadera having almost half of the HHs with food consumption gaps (48% of HHs with borderline or poor FCS[6]), fewer HHs (11%) were found to have purchased goods on credit or sold productive assets to access food. This is probably because a relatively high proportion of HHs in Hagadera (59%) had reportedly received humanitarian food assistance in the 30 days prior to data collection (see figure 13), thus enabling some HHs to meet their food needs without resulting to negative livelihood coping mechanisms.

On the other hand, Ifo was found to have a relatively high proportion of HHs that were not only experiencing food consumption gaps, but also using negative strategies to cope with a lack of access to adequate food (46% of HHs with borderline or poor FCS). Furthermore, almost half (48%) of HHs commonly purchased food on credit, sold HH assets, spent savings, or begged to access food or get money to buy food. This is likely because fewer HHs in Ifo (40%) compared to Dagahaley and Hagadera reportedly received humanitarian food assistance in the 30 days prior to data collection (see figure13). In addition, Ifo reportedly had relatively high proportions of HHs that were depending on remittance (15%) or without access to income (19%). Moreover, **fewer HHs in Ifo reportedly had members who operated businesses** (See figure 14), thus HHs were at a higher risk of experiencing food insecurity in the event of reduced humanitarian funding.

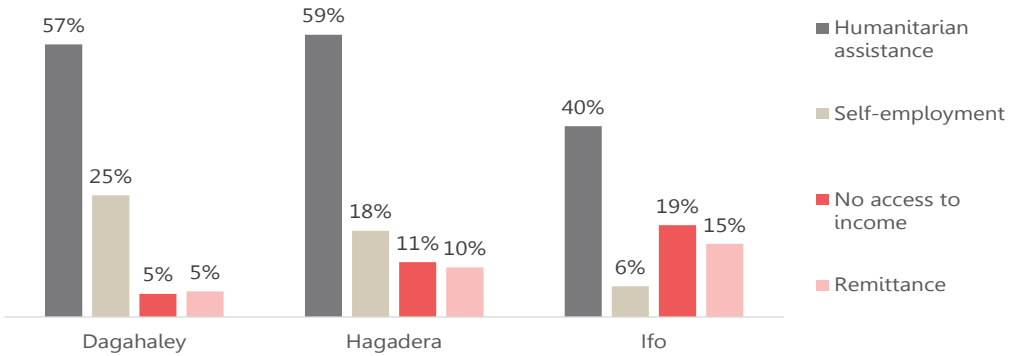
LIVELIHOODS

INCOME:

Overall, the proportion of HHs that were relying on humanitarian assistance as their primary source of income **increased across all the camps**. Over half of HHs (52% up from 48% in November 2021) and 21/25 KIs reported humanitarian assistance to be the community's primary source of income in the 30 days prior to data collection. Specifically, the proportion of **HHs reporting humanitarian assistance to be their primary source of income increased by 53%, 52% and 38% in Dagahaley, Hagadera and Ifo** respectively.

On the other hand, the proportion of HHs that reported self-employment as their primary source of income decreased across all the camps. In particular, the proportion of HHs reporting self-employment as their source of income **decreased by 16%, 8%, and 6%, in Hagadera, Ifo and Dagahaley** respectively. Furthermore, **12% of HHs reported having members who did not have any source of income** in the 30 days prior to data collection, suggesting that some community members were not engaging any income generating activities and thus commonly relying on humanitarian Aid.

Figure 13: Most common sources of income in the 30 days prior to data collection, reported by HHs having some form of income[8]:



This situation could have been potentially exacerbated by the drought situation, as the majority of KIs (21/25) perceived that the ongoing drought in Northern parts of Kenya had decreased access to food for most HHs, thus deepening HHs reliance on humanitarian assistance. Even so, community members were reportedly involved in other income generating activities besides humanitarian assistance and self-employment (See figure 14).

8: Respondents could select more than one answer.

Movement restrictions, a lack of documentation and capital to scale up were the commonly reported challenges among 39% of HHs that reported having at least one member operating a business. For instance, 19/25 KIs reported that community members **lacked freedom of movement,** commonly among unregistered community members. Furthermore, over half of HHs (51%) and 17/25 KIs reported a **lack of access to funds to restock their business** as challenge that business owners faced. Moreover, 35% of HHs reported that community members operating a business **lacked business permits**. This indicates that a lack of documentation and inadequate credit facilities served as barriers among business owners who wanted to expand their businesses.

Figure 14: Top reported businesses in the camps, as reported by KIs (n=25):[8]

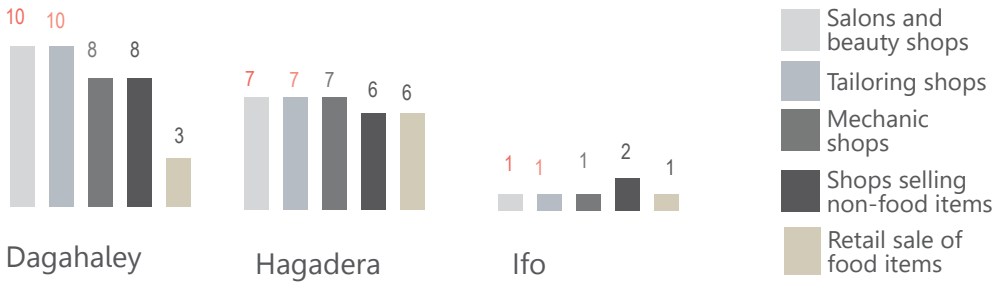
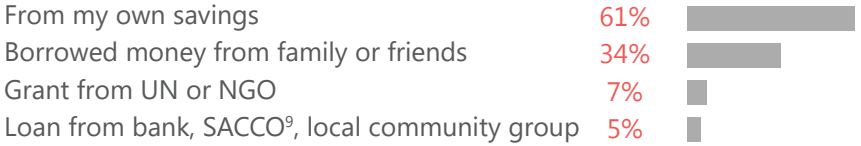


Figure 15: Commonly reported sources of capital, among HHs with a member operating a business, by proportion of HHs:[8]

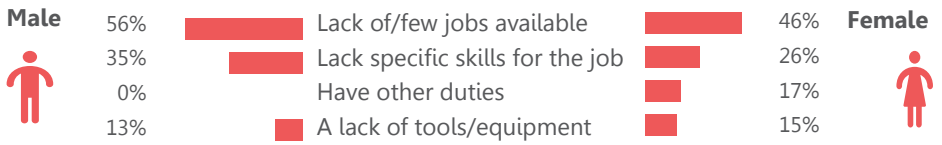


SKILLS, TRAINING AND EMPLOYMENT:

HHs reported having at least one female or male member, aged 18 years and older, who had skills, attended training or had working experience (54% of HHs with males and 43% with females). However, some of these HH members were not using their skills and experiences, commonly because there were reportedly **few job opportunities** or the skills that they possessed did not match the kind of **jobs that were available.** This suggests that HH members are likely in need additional information on how to access to job opportunities, as found in the Information Needs Assessment conducted by REACH in August 2021.

9: Savings and credit cooperative society

Figure 16: Commonly reported reasons why members with skills and work experience were not using their skills, by proportion of HHs:[8]



HOUSEHOLD DEBT:

A relatively high proportion of HHs (82%) reported having borrowed some money from family, friends, traders, etc. at the time of data collection. **Of these, 85% reportedly borrowed the money to buy food**, 40% borrowed money to meet other basic HH needs and 24% borrowed money to pay for health care. **Over-reliance on debt to purchase food suggests that HHs were struggling to meet their food consumption needs, further indicating that HHs were facing food consumption gaps.**

Figure 17a: Average HH debt, per camp (in KES):

Ifo	12,762
Dagahaley	10,768
Hagadera	6,492

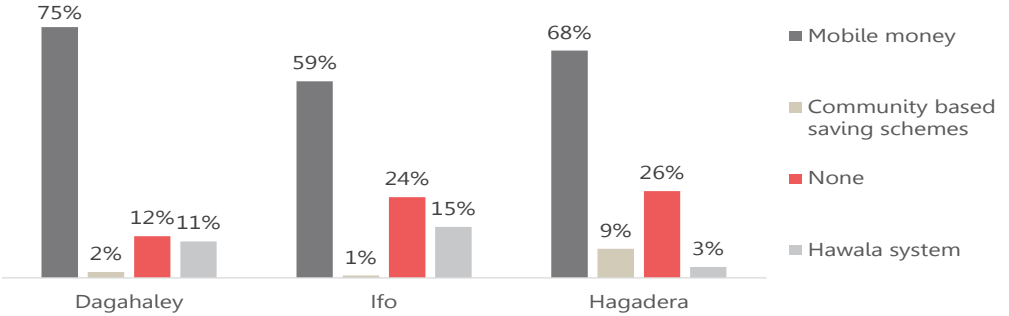
Figure 17b: Proportion of HH income spent on food, per camp:

Ifo	65%
Dagahaley	58%
Hagadera	61%

FINANCIAL INSTITUTIONS:

The availability and access to financial institutions is a key part of HHs' livelihood. The proportion of HHs that reported having access to mobile money increased from 59% in the November 2021 to 67% in October 2022.

Figure 18: Commonly reported financial institutions accessed by HHs reporting to have access to financial institutions in Dadaab refugee camps:[8]



Funded by European Union Humanitarian Aid
NRC NORWEGIAN REFUGEE COUNCIL
REACH Informing more effective humanitarian action

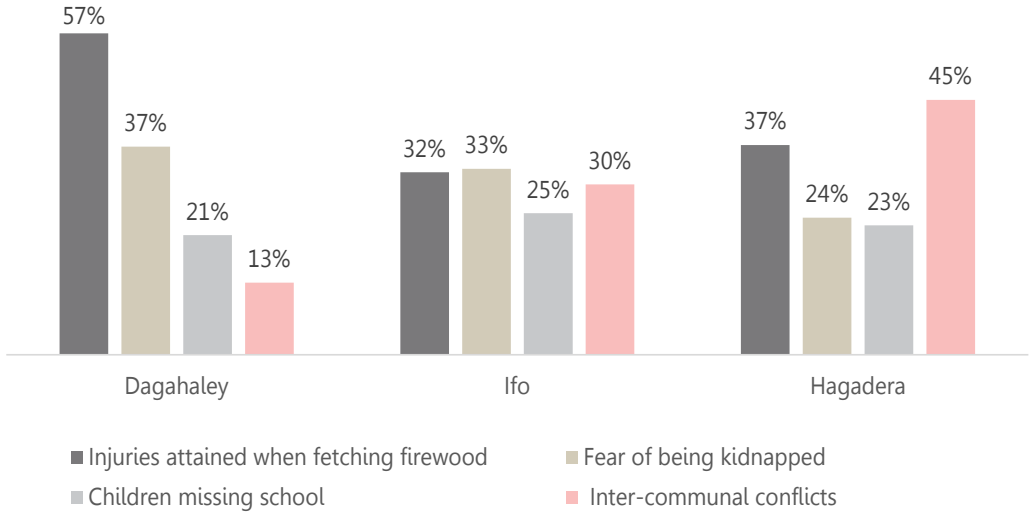
Despite the increase in the proportion of HHs with access to mobile money, **21% of HHs, reported not having access to any type of financial institution.** Considering that 54% of business owners reported lacking money to expand their business, limited access to financial institutions potentially reduces access to credit for business owners, thus serving as a barrier for business people who wish to scale up their businesses.

ENERGY:

Despite the negative health and environmental impact caused by using firewood and the burning of charcoal, 76% and 23% of HHs in Dadaab reported using **firewood** and **charcoal** respectively, as their main source of fuel for cooking.

While firewood provides heat and allows cooking, findings suggest that it creates challenges for HHs, such as perceived tension between the refugees and the host community, the fear of being kidnapped, and injuries related to firewood collection. Furthermore, fetching firewood potentially exposed girls and women to physical and sexual harassment/violence, since more than half of the KIs (13/25) reported that women and girls felt unsafe when going to collect firewood.

Figure 19: Most commonly reported challenges faced while fetching or using firewood, reported by HHs encountering challenges:[8]



10. Early childhood education (ECD).

EDUCATION

The proportion of school-aged[2] children who were reportedly not attending school at the time of data colletion reduced slightly, between November 2021 and October 2022. Among all school-aged boys and girls in the assessed HHs, a slightly higher proportion of girls (17%) than boys (15%) were reportedly not attending school in the 12 months prior to data collection.

Figure 20: % of HHs with school-aged boys, per amount of school-aged boys reportedly attending school (ECD[10], primary, and secondary) in the 12 months prior to data collection:

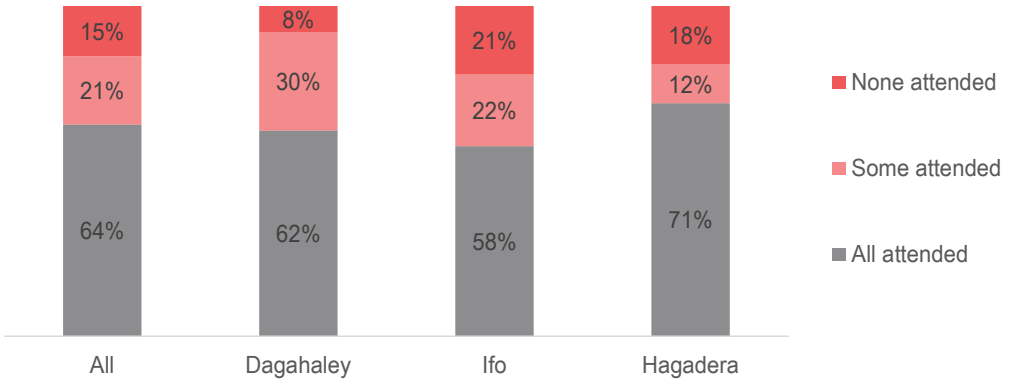


Figure 21: % of HHs with school-aged girls, per amount of school-aged girls reportedly attending school (ECD[10], primary, and secondary) in the 12 months prior to data collection:

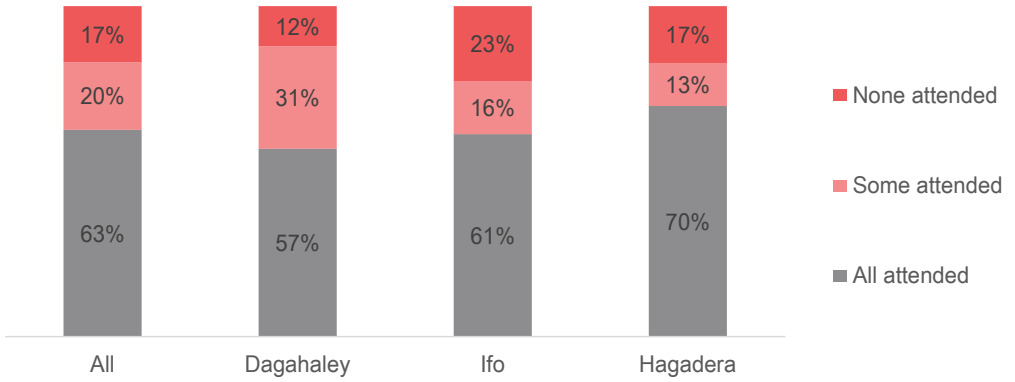
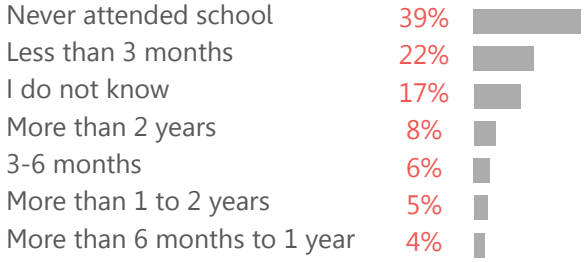


Figure 22: Proportion of HHs reporting the last time that children who were not accessing education, attended school:



Findings suggest that **a relatively higher proportion of school-aged children who were not attending school were between the age of 4 and 9 years**. Over two-thirds of HHs with school-aged children who were not attending school (68% and 69% of HHs with girls and boys respectively) were found to be aged between 4 and 9 years.

On the other hand, over one-third of HHs with school-aged children who were not attending school (39% and 35% of HHs with girls and boys respectively) were found to be aged between 10 and 17 years.

The top reported reason among HHs with school-aged children who were not attending school, was that parents and guardians perceived their **children to be too young to attend school**. More than half (54%) of the HHs with parents and guardians who perceived that school-aged children were **too young to attend school preferred their children to first attend Madrassa[3] classes.** Moreover, 38% of HHs **feared that their children would be exposed to violence on their way to school.**

Boys and girls of school-going age reportedly encountered barriers in accessing education. The top reported barriers to accessing education among HHs with girls who were attending school were: **the long distance to school** and **early marriages/pregnancies** (23%), and **parents lacking awareness about education opportunities** (19%). On the other hand, the top reported barriers among HHs with boys who were attending school were: **the long distance to school** (14%), and a **lack of school fees and/or school-related costs** (11%). Additional information on barriers in accessing education services can be found in the Actors and services mapping conducted by REACH in May 2022.

Furthermore, 13% of HHs reported that they had at least one member of their HH who did not transition to tertiary education after completing secondary school in the five years prior to data collection. The top reported barriers for these HH members not transitioning to tertiary education were the **inability to pay for school fees and stationary** (42%) or **preferred working** (30%).

WATER, SANITATION AND HYGIENE

WATER

At the time of data collection, community members reportedly had access to safe water for drinking, cooking, and domestic hygiene. The majority (91%) of HHs were found to be using improved water sources as their main source of water for drinking and other HH use.

Even so, some HHs reportedly encountered challenges in accessing water sources. More than one-third (35%) of HHs reported having challenges in accessing water. The top reported challenges were **long waiting/queuing time**, **a lack of enough storage containers**, and **a lack of enough water at the source**. Whereas Sphere standards recommend a queuing time of less than 30 minutes, 12% of HHs reported walking for over 30 minutes to fetch water. Moreover, 30% of HHs reported having to wait for over 30 minutes for their turn to fetch water at the water points, indicating that some water points were overstretched and could potentially breakdown.

Table 4: Average volume of water used for drinking and domestic hygiene per HH, per day:

	Average litres of water consumed per HH, per day	Average HH size	Average litres of water used per HH member, per day
Dagahaley	126	6	21
Hagadera	110	7	15.7
Ifo	139	6	23

On average, HH members across all the camps used over 15 litres of water per day, which is above the minimum of 15 litres per person, per day according to the Sphere standards (See table 4). In spite of that, 31% of HHs reported that members could not access adequate water for drinking and domestic use. Among HHs that reported not having access to adequate water to meet their HH's needs, more than half (56%) reportedly **fetched water at another water point further away** and 48% **reduced the consumption of water for hygiene practices** to cope with the lack of sufficient water.

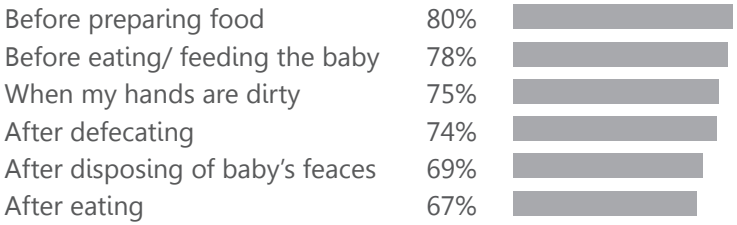
Most notably, HHs in Hagadera seemed to be struggling to access adequate water for drinking and domestic use, with the majority (82%) **fetching water at another water point far than normal,** and over two thirds (35%) **reducing water consumption for hygiene practices.** This is so because HH members reportedly used an average of 15.7 litres of water per day, that is slightly above the minimum quantity as per the Sphere standards. This suggests that HHs were spending time meant for other vital activities while fetching water.

HYGIENE AND SANITATION

At the time of data collection, about 10% of HHs reported not having soap, which potentially minimised their ability to maintain good hygiene practices. Among these, the majority (83%) reported that they were waiting for the next distribution while 21% reported not being able to afford soap.

Forty-two percent (42%) of HHs in Dadaab camps reportedly washed their hands during all the critical hand washing occasions, 56% reportedly washed their hands during some critical hand washing occasions while 2% reported not washing their hands at all during any critical hand-washing occasion. HHs with members who did not wash their hands during the critical hand washing occasions **might be at elevated risk of contracting hygiene-related diseases.**

Figure 23: % of HHs that reportedly washed their hands during the following critical hand-washing occasions:[8]



Despite the majority of HHs reporting having a sanitation facility, challenges still persist regarding access to such facilities. The majority (94%) reported having latrines. Among these, 66% reported sharing their latrine with other HHs and 29% reported that the shared sanitation facilities did not have separate stalls for women, respectively.

Furthermore, KIs reported that **sanitation facilities did not have sufficient privacy, were overcrowded, and cesspits were full and hence exposing the community to the risk of contacting bacteria that cause waterborne diseases**.

A relatively high proportion of HHs in Dagahaley (62%) reportedly received hygiene promotional messages in the 30 days prior to data collection. These HHs might have employed the knowledge gained from those messages to ensure that their sanitation facilities were clean, since a relatively fewer proportion of HHs (7%) in Dagahaley reported latrines being unclean as a barrier in accessing sanitation.

Figure 24: Commonly reported problems that community members encountered while accessing sanitation facilities (latrines), by proportion of HHs, per camp:[8]

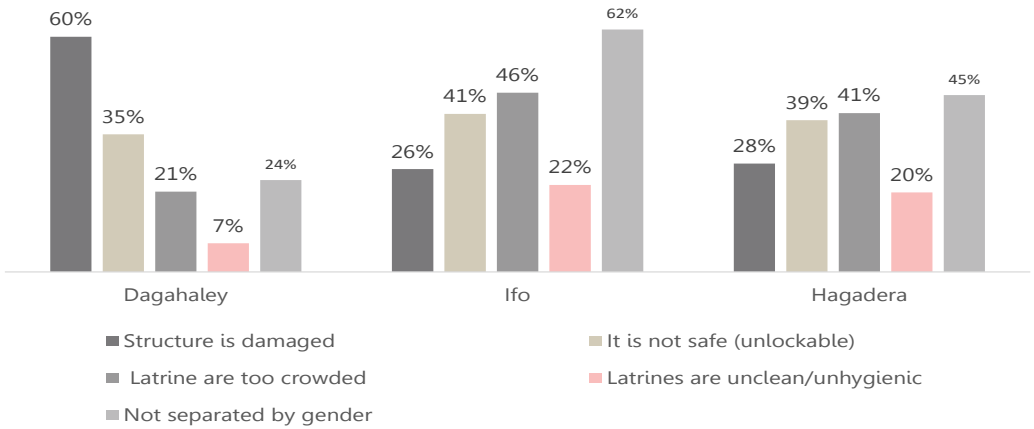
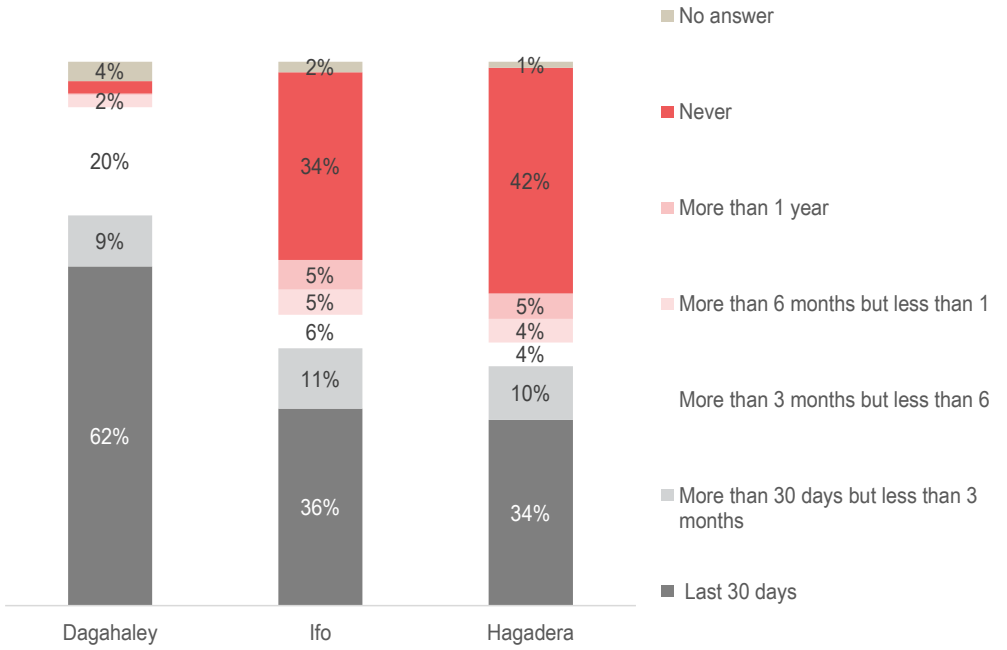


Figure 25: % of HHs that reported having received hygiene promotion messages in the following timelines:

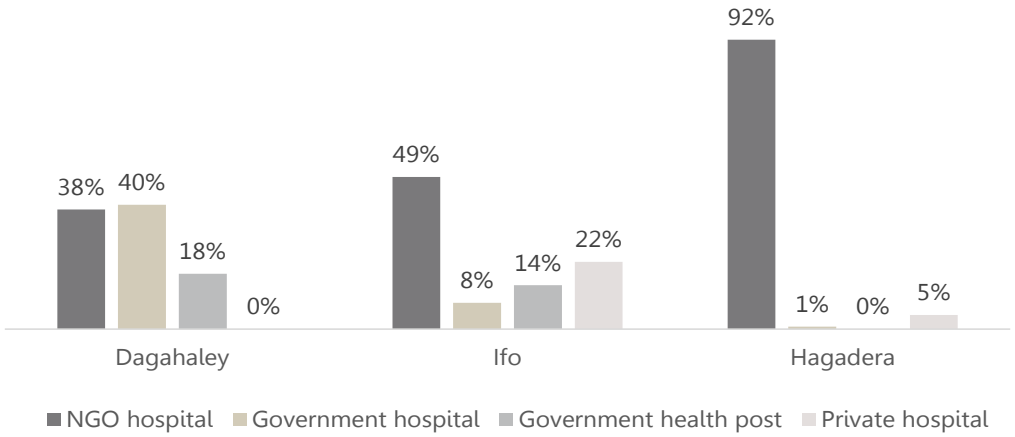


HEALTH

Overall, the proportion of HHs that reported having been charged to access healthcare decreased (8% down from 18% in November 2021). The services that were commonly charged include consultation, treatment and/or pharmacy, which potentially served as barriers in accessing healthcare.

Among HHs (27%) that reported having at least one member that had a health problem and needed to access health care in the 3 months prior to data collection, about two-thirds (67%) reported that community members commonly **sought healthcare from a hospital run by a non-governmental organization (NGO),**

Figure 26: % HHs that would visit the following types of health facilities if they experienced a health issue:[8]



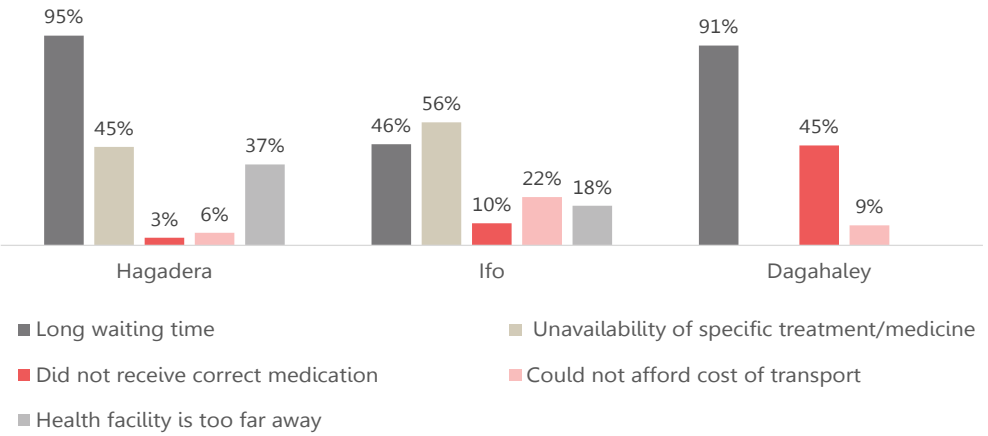
Despite HH members being able to walk to a nearest health facility to access healthcare, they reportedly encountered barriers in accessing healthcare. The majority (81%) of HHs reported the **long queuing time** to be a barrer. In addition, about half of the HHs (45%) reported **unavailability of specific medicine and/ or treatment** in some health facilities.

Furthermore, among HHs that had a member who needed health care but could not access it, 43% cited the **long waiting time** as the reason they could not access healthcare. Moreover, 17% of HHs with members who sought healthcare services in the three months prior to data collection reported being dissatisfied, likely because of the **long queuing time**.

The majority (94%) of HHs reported that it took less than one hour for a member from their HH to reach a health facility that is nearest to their home, the majority (92%) of whom walked on foot.

Thus, community members were able to access a health facility within a standard time based on the minimum requirements outlined in the Sphere standards (A minimum of 80 percent of population that can access primary healthcare within one hour's walk from dwellings).

Figure 27: Commonly reported barriers that community members encountered while accessing healthcare services, per % of HHs, per camp:[8]



NUTRITION

While most community members who sought nutrition services reportedly received them, there were some reported challenges in accessing such services. Specifically, 19% of HHs reporting having at least one member who sought nutrition assistance in the 6 months prior to data collection. Of these, the majority (93%) reportedly received services.

Even so, community members reportedly experienced challenges in accessing nutrition services. The commonly reported challenges that HH members encountered while seeking nutrition services were: **a lack of awareness of available nutrition services** (33%), and **unavailability of nutrition services** (20%). Notably, 60% of HHs in Hagadera reported not having information on where to access nutrition services.

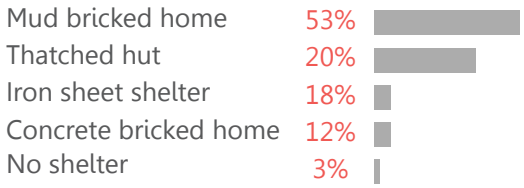
Furthermore, 40% of HHs in Dagahaley reported that nutrition services were unavailable. On average, 27% and 14% of HHs with children below 5 years and pregnant/lactating mothers respectively, had been screened for malnutrition, in the six months prior to data collection.

Table 5: % of HHs per camp, per amount of children below 5 years and pregnant/lactating mothers who had reportedly been screened for malnutrition in the six months prior to data collection:

	Children under 5 years			Pregnant/lactating mothers		
	Yes	No	Do not know	Yes	No	Do not know
Dagahaley	26%	69%	5%	15%	79%	6%
Hagadera	30%	70%		18%	82%	
Ifo	25%	75%		10%	89%	1%

SHELTER

Figure 25: Reported types of shelters by % of HHs:[8]



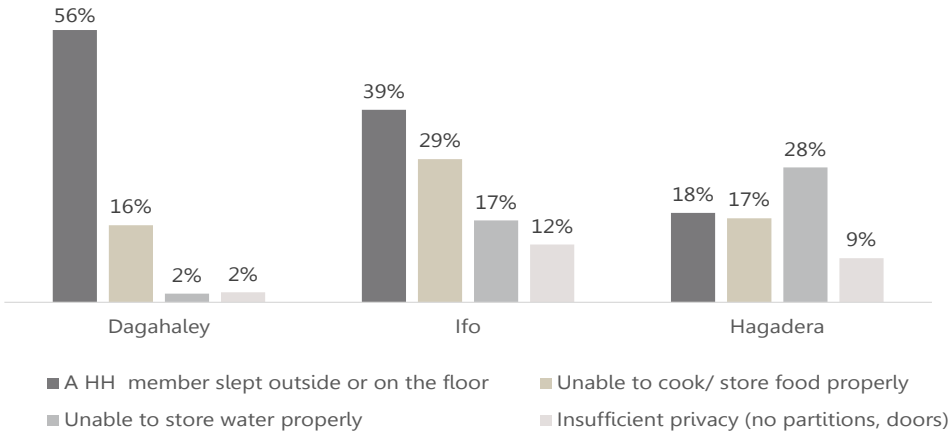
Despite the majority of HHs reporting having shelter for their members, challenges exist, with some community members reportedly living in damaged structures, shelters having enclosure issues or HHs lacking adequate space for every member. Almost half (45%) of the HHs reported being in need of shelter materials, supported by the majority of KIs (22/25) who reported that **shelter/ housing was a top priority need for most community members**.

The majority of KIs (18/25) reported that some community members (half or a little less than half) in the camp lived in either an inadequate shelter, a moderately to highly damaged shelter, or no shelter. Furthermore, about two-thirds (32%) of HHs reported that their shelters had been damaged in the 3 months prior to data collection. Of these, 42% commonly reported that the roofs of their shelters had been damaged. In addition, about two-thirds of HHs (65%) reported that their shelters were damaged by strong winds.

Moreover, some HHs reported that their shelters had enclosure issues that potentially caused living conditions in such HHs to be uncomfortable. Particularly, 39% of HHs reported having shelters that leaked when it rained. Of these, a higher proportion (44%) of HHs were reported to be in Dagahaley.

More than half (15/25) of KIs and 37% of HHs reported having at least one member who had to sleep outside or on the floor because of insufficient space or insufficient sleeping mats/mattress. In particular, more than half (56%) of HHs **in Hagadera reported having at least one member who had to sleep outside or on the floor because of insufficient space.** This suggests that community members in Hagadera have higher shelter needs compared to other camps.

Figure 26: % of HHs reporting issues that HH members faced in terms of living conditions in their shelters, per camp:[8]

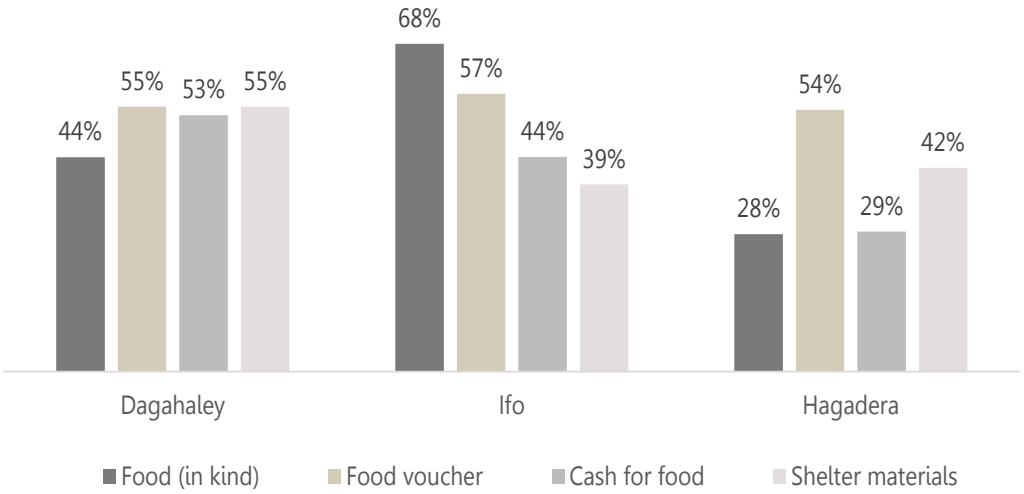


HUMANITARIAN ASSISTANCE

Findings indicate that food security remains to be a priority need for HHs in the Dadaab refugee camps. The majority of HHs (77%) reporting having received food assistance (in-kind, voucher, or cash for food) in the 30 days prior to data collection. However, 46%, 55% and 42% of **HHs reported food (in kind), voucher, and cash for food to be the top priority needs** at the time of data collection, respectively.

In addition, almost all of KIs reported food (24/25) and shelter (22/25) to be among the top priority needs for most community members. This indicates that besides food assistance, community members are also in need of **shelter** assistance.

Figure 27: % of HHs reporting the top priority needs at the time of data collection:[8]



The majority (61%), 39% and 35% of HHs across the three camps commonly reported having received food, water and hygiene assistance respectively (every month), in the six months prior to data collection.

Among HHs that received humanitarian assistance, the majority (88%) reported being satisfied with the assistance received, and the process of delivery of assistance. Among HHs that reported being dissatisfied (12%), the majority (86%) perceived that the assistance **was not enough to meet their HH needs** while 31% perceived that the assistance was of low quality.

CONCLUSION

Despite the majority (95%) of HHs in Dadaab refugee camps reporting having received humanitarian assistance in the 6 months prior to data collection, a complete fulfillment of all refugees' needs is far from being achieved. For instance, in the food security sector, food consumption gaps still exist, with some HHs resorting to unsustainable livelihood-based coping strategies to access food. A high proportion of HHs were also borrowing money, commonly to buy food.

- The protracted drought situation in the Northern parts of Kenya potentially weakened the purchasing power of most HHs, and led to HHs over-relying on humanitarian assistance. More than half (56%) of the HHs reportedly encountered challenges due to drought, particularly **paying for basic goods due to inflation, thus reducing their ability to access different varieties of food.**

- Documentation and access to information on how to obtain it, **still remains a challenge for some refugees in Dadaab refugee complex.** Community members without proper documentation reportedly **encountered challenges in accessing basic services** and also faced **movement restrictions** that negatively impacted small traders in the camps. A lack of documentation thus served as a barrier to community members who needed access to basic services.

- Whereas the majority of HHs (76%) were found to be using firewood for cooking, fetching firewood reportedly exposed community members to various challenges. The reported challenges include injuries, communal conflicts, children missing school and health hazards caused by smoke. Most notably, fetching firewood exposed girls and women to physical and sexual abuse, as more than half of KIs (13/25) cited that **girls and women felt unsafe on their way to collect firewood.**

- Community members reportedly encountered some barriers in accessing health facilities. The majority (81%) of HHs perceived the **long waiting time** to be a **barrier to most community members who sought healthcare in the camps.**

- A considerable proportion of adult males and females could not access jobs, despite having job skills, working experience or vocational training. HHs commonly cited **few jobs opportunities,** the **lack of tools and equipment** and **a lack of specific skills for the jobs that were available** as reasons why community members were could not access jobs.